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Select Committee on Drugs

HEARINGS

HELD AT

PARLIAMENT BUILDINGS

TORONTO ONTARIO

VOLUME No.:

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--- On resumed SELECT COMMITTEE ON DRUGS

Proceedings of hearings
held at Parliament Buildings,
Toronto, Ontario, on Monday,
the 12th of June, 1961,
Committee, at 2.45 p.m. us this afternoon some repre-

sentatives from general hospitals throughout Ontario.

COMMITTEE:

The first witness will be Mr. C.A. Sage, associate

MR. H.L. ROWNTREE, Q.C. -- Chairman
director of the Hospital for Sick Children, Toronto.

Mr. Sage, come forward please. Mr. Sage, for the

MR. A. WREN

purpose of the record will you inform us what your

MR. J.A. FULLERTON

full name is please.

MR. J. TROTTER

MR. SAGE: Cornelius A. Sage.

MR. R.E. SUTTON

MR. RICE: And what is your position?

MR. R.J. BOYER

MR. SAGE: Associate director of the

MR. N. WHITNEY

Hospital for Sick Children.

MR. H.J. PRICE

MR. RICE: And how long have you held

MR. K. BRYDEN

that position?

MR. J. WHITE

MR. SAGE: I have held that position

MR. G.F. LAVERGNE

about two years.

MR. RICE: What did you do prior to that

time?

MR. S.J. GADSBY, F.C.I.S., Secretary

MR. SAGE: I was assistant director and

MR. HAROLD A. RICE -- Committee Counsel

comptroller of the Hospital for Sick Children for ten

MR. W.J. AYERS -- Accounting

years. Consultant to the

Committee

MR. RICE: How long have you been associ-

ated with the Hospital for Sick Children?

MR. SAGE: Just over ten years, nearly

eleven.

MR. RICE: And were you associated with



/dpw

--- On resuming at 2.45 p.m.

THE CHAIRMAN: Mr. Rice?

MR. RICE: Mr. Chairman, members of the Committee, we have with us this afternoon some representatives from general hospitals throughout Ontario. The first witness will be Mr. C.A. Sage, associate director of the Hospital for Sick Children, Toronto. Mr. Sage, come forward please. Mr. Sage, for the purpose of the record will you inform us what your full name is please.

MR. SAGE: Cornelius A. Sage.

MR. RICE: And what is your position?

MR. SAGE: Associate director of the Hospital for Sick Children.

MR. RICE: And how long have you held that position?

MR. SAGE: I have held that position about two years.

MR. RICE: What did you do prior to that time?

MR. SAGE: I was assistant director and comptroller of the Hospital for Sick Children for ten years.

MR. RICE: How long have you been associated with the Hospital for Sick Children?

MR. SAGE: Just over ten years, nearly eleven.

MR. RICE: And were you associated with

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The first witness will be Mr. C.A. Sage, associate

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Mr. Sage, come forward please. Mr. Sage, for the

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full name is please.

MR. SAGE: Cornelius A. Sage.

MR. RICE: And what is your position?

MR. SAGE: Associate director of the

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MR. RICE: And how long have you held

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MR. RICE: What did you do prior to that

time?

MR. SAGE: I was assistant director and

comptroller of the Hospital for Sick Children for ten

years.

MR. RICE: How long have you been associ-

ated with the Hospital for Sick Children?

MR. SAGE: Just over ten years, nearly

MR. RICE: And were you associated with



any other hospital?

MR. SAGE: No, I was assistant director of the Blue Cross Association of Ontario for ten years.

MR. RICE: I understand that you have a brief you wish to present on behalf of the Hospital for Sick Children?

MR. SAGE: Yes sir, I have distributed copies. I gave 20 copies to Mr. Gadsby.

MR. RICE: Will you proceed with your brief sir?

MR. SAGE: Yes.

MR. BRYDEN: Before Mr. Sage proceeds Mr. Chairman I take it the public address system is not switched on or something. It doesn't seem to be working.

(Public address system fixed).

MR. SAGE: Mr. Chairman, gentlemen, in presenting this we had in mind some instructions which we received from the Ontario Hospital Association and we tried to break it down between administration, purchasing, storage, inventory, distribution, narcotics, formulary, manufacturing, analysis, accounting, summary, and I tried to cover those in the brief under these headings.

I have a short history which may not be too closely associated with the subject. In view of the lateness of the hour I would be glad to pass over from that one section ---



THE CHAIRMAN: In view of what sir?

MR. SAGE: The lateness of the hour sir.

THE CHAIRMAN: The what? I didn't hear you.

MR. SAGE: The lateness of the hour. I am pressed for time. I explained that to Mr. Gadsby. I would be glad to read it sir if you would like to have me.

MR. RICE: I believe he is just going to skip the first part, history of the hospital.

THE CHAIRMAN: What does he mean "the lateness of the hour"?

MR. RICE: I am not sure.

MR. GADSBY: I think Mr. Chairman to make sure there would be no delay he wanted to get through.

THE CHAIRMAN: My understanding was it was 2.30 today.

MR. GADSBY: That is right.

THE CHAIRMAN: What do you mean lateness of the hour? I don't understand you.

MR. SAGE: It's 2.45. That is what I meant sir.

THE CHAIRMAN: Would you proceed please.

MR. SAGE: Commencing with the administration section, if I may.

MR. RICE: Mr. Sage for completeness' sake would you include the whole of your brief. Read it all. Start with the history.

MR. SAGE: Very well. This is a short



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MR. RICE: Mr. Sage for completeness;
would you include the whole of your brief. Read
it all. Start with the history.
MR. SAGE: Very well. This is a short



history of the hospital.

I. HISTORY

A brief introduction to the Hospital from which this report emanates might be in order. Established in 1875, the first recorded minute reads as follows:

"On the first day of March 1875, the house No. 31 Avenue Street was rented. It had a mansard roof and a basement and was rented at \$320.00 per annum --- six iron cots were sent in and a hall stove was promised".

While it must be assumed that some medicines and drugs were available in those days, probably from the staff doctors' personal pharmacy, no record of a hospital dispensary appears until the year 1890 when a medical resident officer was taken on the staff:

"It will be his duty to take charge of the dispensary and prepare all medicines ordered --- he shall compound and make up all medicines for both indoor and outdoor patients and affix labels to every bottle, box or powder --- all out patients must provide their own phials or vessels for medicine and these must be kept clean".

Seventy years ago the principle of protection for the patient against an unmarked medicine bottle was established by the Ladies Trustee Board of that



History of the Hospital.

I. HISTORY

A brief introduction to the Hospital from which this report emanates might be an order. Established in 1875, the first recorded minute was as follows:

"On the first day of March 1875, the house No. 31 Avenue Street was rented. It had a mansard roof and a basement and was rented at \$300.00 per annum and six iron beds were sent in and a hall above was promised".

While it must be assumed that some medicines and drugs were available in those days, probably from the staff doctors' personal pharmacy, no record of a hospital dispensary appears until the year 1891 when a medical resident officer was taken on the staff:

"It will be his duty to take charge of the dispensary and prepare all medicines ordered --- he shall compound and name up all medicines for both indoor and outdoor patients and affix labels to every bottle, box or powder --- all our patients must provide their own pills or vessels for medicine and these must be kept clean".

Seventy years ago the principle of protection for the patient against an unmarked medicine bottle was established by the Ladies' Trustee Board of that



day and has continued ever since. It is a rare occasion now that a medical doctor is called upon to compound a prescription in this hospital but he can still do so if required.

In his place, in the present Hospital for Sick Children, with a rated capacity of 647 beds, there are 6 Pharmacists, not including the Chief Pharmacist, who prepare an average of 413 prescriptions every day, allocate supplies to 21 wards, and manufacture a large number of solutions and ointments so essential to the care and treatment of six hundred sick children.

2 THE CHAIRMAN: I am rather amazed here at what I call your obstreperous remark at the opening of your presentation when you talk about the lateness of the hour. You are talking about 1865 and 1875. I think you are just being a little bit facetious when you opened your remarks with that observation and I just tell you that because there happen to be some others of us here who have others things to do as well as look into the cost of drugs and the administration of them.

MR. SAGE: No facetiousness was intended Mr. Chairman. I thought I would save your time. That was the only reason for that remark.

THE CHAIRMAN: I just make that observation to you sir, at the same time when you open a brief and talk about 1875 and start talking about the lateness of the hour. I will just leave it at that.



day and has continued ever since. It is a rare occurrence now that a medical doctor is called upon to compound a prescription in this hospital but in the past it was so frequently required.

In his place, in the present Hospital, for Sick Children, with a rated capacity of 60 beds, there are 6 Pharmacists, not including the Clinical Pharmacist, who prepare an average of 413 prescriptions every day, allocate supplies to 61 wards, and manufacture a large number of solutions and ointments so essential to the care and treatment of sick children.

THE CHAIRMAN: I am rather amazed here at what I call your obstreperous remark at the beginning of your presentation when you talk about the lateness of the hour. You are talking about 1875 and 1877. I think you are just being a little bit facetious when you opened your remarks with that observation and I just tell you that because there happen to be some others of us here who have other things to do as well as look into the cost of drugs and the administration of them.

MR. SAGE: No facetiousness was intended. Mr. Chairman, I thought I would save your time. That was the only reason for that remark.

THE CHAIRMAN: I just want to mention to you sir, at the same time when you open a brief and talk about 1875 and start talking about the lateness of the hour. I will just leave it at that.



MR. SAGE: Thank you very much. May I proceed now Mr. Chairman?

THE CHAIRMAN: Please do.

MR. SAGE: II. ADMINISTRATION: In general, the policies and operative procedures for the hospital pharmacy are made as definite and clear as possible and stem from the Board of Trustees and Administrator upon the advice of the Pharmacy Committee or, if necessary, the Medical Advisory Board. The Pharmacy Committee comprised of a medical doctor representative from each of the five clinical services, the Assistant Director, the Director of Nursing, the Purchasing Agent and the Chief Pharmacist, meets monthly. It is chiefly concerned with the relationship of the Pharmacy organization to the medical departments and nursing service - recommends revisions to procedures for distribution, approves drugs to be placed on the wards, and reviews new drugs which come on the market from time to time. The Chairman of the Pharmacy Committee is Dr. Code Smith of the Anaesthetic Service. Addendum "A" attached, gives a listing of Pharmacy Committee regulations.

From the administration standpoint, stress is placed on the importance of close co-operation between the Purchasing agent, the Chief Pharmacist and the Stores manager, all of whom report to the Assistant Director.

The Hospital for Sick Children, in view of its size and scope, may be considered a major

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The Hospital for Sick Children, in view

of its size and scope, may be considered a major



business undertaking, as well as a childrens' medical centre, and in this respect the purchase and distribution of drugs plays an important part.

III. PURCHASING

Apart from obtaining all data on new drugs from the monthly meetings of the Pharmacy Subcommittee the hospital Pharmacist and Purchasing Agent make a practice of meeting with drug representatives twice a week.

At these meetings comparisons in price are sought on like drugs and whenever possible full advantage is taken of any price betterment. Similarly, on drugs in heavy demand by the hospital, we endeavour to buy on a yearly basis with split deliveries thereby taking advantage of further discounts which otherwise might not be obtainable.

Requisitions for drug purchases originate at two points:

(a) Staple drugs as authorized by the Pharmacy are carried in the Stores Department.

(b) All other drugs are requisitioned for purchase directly by the Pharmacy.

Where staple drugs are carried in stores a maximum and minimum stock has been set by the Pharmacist and Stores Manager. When stock cards indicate that an order should be placed the requisition, drawn up by the Stores Manager, is sent to the Pharmacist for final approval before being sent to Purchasing

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The following are the principles for drug purchases:

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Pharmacy are carried in the Stores

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and Stores Manager. When stock cards indicate

that an order should be placed the requisition, drawn

up by the Stores Manager, is sent to the Pharmacists

for final approval before being sent to Purchasing



for processing.

Whenever large orders are being considered, tenders are requested on drugs whether stocked in the Pharmacy or Main Stores. All tenders received are discussed with the Pharmacist and an agreement on price and quality is reached before an order is placed. Where a bulk order is placed and split shipments are requested, should a price reduction occur in the market, such reductions are passed on to the hospital. Should the drugs on hand become aged, such drugs can be returned to the supplier for full credit and future shipments can be adjusted to fit present consumption. The Pharmacist receives a copy of all orders placed directly by his department.

Effective drug buying requires the close co-operation of both Pharmacist and Purchasing Agent. When such co-operation exists between these two departments, greater competition ensues among the distributors and manufacturers to the benefit of the hospital.

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/AG/hm

As mentioned previously under Purchasing, drugs are stored in two locations.

(a) Main Stores

Bulk drugs, and large quantities of chemicals and pharmaceuticals are stored in Main Stores, one floor below ground level. These include certain inflammable materials, such as ether and alcohol, acetone and ethyl chloride. Other dangerous materials are also stored in suitable areas where explosion risks are reduced to a minimum, and where the risk of contamination by acids and corrosive fluids is negligible.

Drugs, and Pharmaceuticals in constant use are placed in convenient locations. All stocks are subject to strict stock control, which reduces risk of obsolescence or over-stocking.

Lists of these commodities are kept in the Pharmacy and the drugs are issued daily upon receipt of the standard requisition form, signed by the Chief Pharmacist. (See Addendum F).

(b) Pharmacy Stores

The Pharmacy stock room provides space for less bulky pharmaceuticals ---

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(b) Pharmacy Stores

The Pharmacy stock room provides space for

less bulky pharmaceuticals ---

THE CHAIRMAN: Could we just stop for a moment



and look at form F. Who may sign that form and make it effective?

MR. SAGE: The standard requisition form, the Chief Pharmacist.

THE CHAIRMAN: What other signature will make it binding?

MR. SAGE: That is all that is required for its issue.

THE CHAIRMAN: Can a nurse sign it?

MR. SAGE: No, the nurse does not ordinarily order these supplies.

THE CHAIRMAN: I don't mean ordinarily. Who can sign it?

MR. SAGE: The Chief Pharmacist only.

THE CHAIRMAN: Does this form operate over the signature of a nurse?

MR. SAGE: Not for this particular supply of drugs. This is a standard requisition form, and in this particular aspect of it it must be signed by the Chief Pharmacist.

THE CHAIRMAN: So the only time that the form referred to in addendum F is effective and operates is over the signature of the Chief Pharmacist, is that right?

MR. SAGE: That is right, yes sir.

THE CHAIRMAN: And if it were signed by a doctor it is not effective?

MR. SAGE: No sir.

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MR. SAGE: That is right, yes sir.

THE CHAIRMAN: And if it were signed by

a doctor it is not effective?



THE CHAIRMAN: It is not effective if it is signed by a nurse or any other employee?

MR. SAGE: In the absence of the Chief Pharmacist, they might come to my office or the director's office.

THE CHAIRMAN: Well, you are not qualifying that now?

MR. SAGE: It depends on where the requisition emanates from.

THE CHAIRMAN: You started off and said it was the Chief Pharmacist, and you are now changing the story. What is the authorizing signature?

MR. SAGE: The authorizing signature is the Chief Pharmacist's.

THE CHAIRMAN: Does any other signature make the form effective?

MR. SAGE: It might in certain circumstances when the Chief Pharmacist is not there.

THE CHAIRMAN: Will you please define them?

MR. SAGE: It would be the director, or the associate director, or in the absence of both of those the deputy director to whom the Chief Pharmacist reports.

THE CHAIRMAN: Your first statement was not accurate then?

MR. SAGE: Are you asking me or telling me?

THE CHAIRMAN: I am asking you?

MR. SAGE: Well, will you put your request in the form of the question?

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THE CHAIRMAN: You said this form was not



effective without the signature of the Chief Pharmacist?

MR. SAGE: I said he was the only one authorized to sign.

THE CHAIRMAN: Now you are changing it?

MR. SAGE: And in his absence one of the chief officials of the hospital.

THE CHAIRMAN: So your first statement was not correct?

MR. SAGE: No, it was not incorrect, it may have been inadequate to an extent.

THE CHAIRMAN: Sir, our process is one here today to get your help, but we want your true help. I say true help in the sense in which I use those words. Please do not make absolute statements when you do not mean them.

MR. SAGE: All right.

--- usually of a more expensive type. These items are also subject to a strict stock control to ensure a minimum wastage.

In the event where certain drugs fall into disuse, an arrangement is in effect where manufacturers will either pass credit for these items or will replace them with new drugs in current use. The importance of this understanding should not be underestimated, as the advancement of medical techniques and knowledge results in a percentage of drugs being constantly superseded in favour of

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new products.

V. INVENTORY

We maintain over 3,000 different items of drugs and pharmaceuticals in our inventory with a total value of \$41,928.00 at December 31, 1960. This inventory valuation is down from the \$45,759.00 held in stock at December 31, 1959.

Although most of these items maintained in inventory would be purchased by an adult hospital, there are many special items which we, as a children's hospital, would normally stock in larger quantities such as vitamins and vitamin preparations. Many other products must be maintained in suspension or in liquid form because they are being administered to infants, for example, penicillin compounds, sulfonamide preparations and gantrisin products.

A physical inventory of all stock is taken at least once a year with the annual count of Main Stores being done at the end of October and the Pharmacy stock itself being counted at the end of December. We do maintain an accurate perpetual record of the stock held in Main Stores and these records are adjusted to the physical count at October 31st. Through machine accounting equipment we are able to provide a monthly list of stock to the stores manager and checks are taken from time to time of the fast moving items so that we can follow up any discrepancies as they occur. By far the largest portion of our drug inventory is held in the Pharmacy stockroom and the Pharmacy refrigerator.



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V. INVENTORY

We maintain over 3,000 different items of drugs and pharmaceuticals in our inventory with a total value of \$41,938.00 as of December 31, 1950. This inventory valuation is down from the \$45,759.00 held in stock at December 31, 1949.

Although most of these items maintained in inventory would be purchased by an adult hospital, there are many special items which we, as a children's hospital, would normally stock in larger quantities such as vitamins and vitamin preparations. Many other products must be maintained in suspension or in liquid form because they are being administered to infants, for example, penicillin compounds, sulfonamide preparations and gentamicin products.

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Preparation for the annual inventory of this stock is begun about November 1st each year when stock cards are headed up with the name of each item held and placed with the stock item. The pharmacy department is generally slack between Christmas and New Years' and the staff are able to concentrate on the physical count. The quantity on hand is entered on the pre-numbered stock card which is located with the product. A representative from our firm of auditors accompanied by our Chief Accountant attends on December 31st and spot checks the physical count. The pre-numbered stock cards are pulled by the auditor and turned over to the accounting department which sorts the cards into numerical order and verifies that all cards have been returned. The stock cards are priced from a detailed card index maintained of all purchases of drugs and pharmaceuticals showing the date of every purchase, quantity purchased, unit prices and the value. Inventory is compared with that taken at the end of the previous year and explanations are noted of any large variation. Slow moving and obsolete stocks are discussed with the Chief Pharmacist who arranges for a return to the supplier for credit. The annual inventory is then turned over to our auditors for their year end verification.

From time to time we have reviewed whether it is feasible to maintain the Pharmacy on a perpetual record and each time we have come to the conclusion that the expense of maintaining the detailed record of the 3,000 items does not warrant the results



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 showing the date of every purchase, quantity purchased,
 unit prices and the value. Inventory is compared with
 that taken at the end of the previous year and explana-
 tions are noted of any large variation. Slow moving and
 obsolete stocks are discussed with the Chief Pharmacist
 who arranges for a return to the supplier for credit.
 The annual inventory is then turned over to our auditors

From time to time we have reviewed

whether it is feasible to maintain the pharmacy on
 a perpetual record and each time we have come to the
 conclusion that the expense of maintaining the detailed
 record of the 3,000 items does not warrant the results



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or the controls which would be obtained. It would be impossible for the pharmacist to stop in the middle of preparing a prescription to record each gram of every ingredient used. The Chief pharmacist does keep a detailed record of every purchase and variations in usage can be checked easily. A weekly check of the stock held in the Pharmacy is made by the Chief Pharmacist to determine the needs for the following week. Our strict stock control and rotation of stocks insures that wastage is at a minimum level and obsolete and out of date stock do not constitute a problem.

THE CHAIRMAN: May I just ask you one question which occurs to me. Are you suggesting that a gram of a prescription is not significant? I am rather interested in your statement in the middle of that paragraph, the last paragraph of Part V on page 4. Is the part of a gram of a prescription not significant in the prescribing of drugs?



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lpw
MR. SAGE: I didn't know I had raised that point at all, and I am not a pharmacist and I couldn't answer that. My implication here is that there wouldn't be time to record every bottle that is taken off a shelf and every record of it at that particular moment.

THE CHAIRMAN: I would think that would be a rather serious implication with respect to the operation of your hospital.

MR. SAGE: Well, it isn't.

THE CHAIRMAN: Proceed.

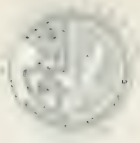
MR. SAGE: VI. DISTRIBUTION: The distribution of drugs in the Hospital takes place in the following three ways:

(a) Ward Stock

All wards are supplied with lists of drugs approved as Routine Drug Stock (see Addendum C) and Emergency Drug Stock (see Addendum D). Replacements of ward stock drugs are ordered in ward books which are sent to the Pharmacy each morning. Baskets are filled and delivered to the nursing stations by porters assigned to this task under the supervision of a Pharmacist.

(b) In-Patient Prescriptions

Certain ward stocks (see Addendum C) must be filled only on an individual prescription and these are replaced



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(b) In-Patient Prescriptions

Certain ward stocks (see Addendum C) must be filled only on an individual prescription and these are replaced



each morning along with the routine stock baskets. Other prescriptions are received in the Pharmacy by pneumatic tube throughout the day. When these prescriptions are prepared they are returned to the ward through the tube system unless they are too large for the container.

Drugs required from the Pharmacy after normal hours can be obtained by the Nursing Supervisor on duty together with a responsible member of the Staff. Requisition forms, signed by the Supervisor and her attendant, are required and these are checked and priced the following day. These requests are not numerous since most requirements can be supplied from ward stocks or emergency cupboards.

(c) Out-Patient Prescriptions

The Pharmacy is situated adjacent to the clinics and approximately 130 clinic prescriptions are dealt with through the out-patient wicket each day. Clinic prescriptions are serial numbered and filled in rotation. The dispensed prescription is kept on file for two years.

Employees and private out-patients also



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purchase drugs through the out-patient wicket. Sales to private out-patients are less than 1% of total prescriptions filled.

VII. NARCOTICS

Strict rules controlling the ordering, supply and administration of narcotics have been issued to all wards and are strictly adhered to. (see Addendum B).

In accordance with the requirements of the Narcotics Act, all narcotic transactions are recorded in the Pharmacy and frequent checks ensure that stocks and registers are in order and up to date.

Narcotic requisitions signed by the Chief Pharmacist are required by suppliers before narcotic drugs will be delivered to the Hospital. When the narcotics are received they are recorded in the narcotic register and stored in a combination safe. Supplies issued are carefully controlled and all details entered in the register.

Dosage charts are supplied to the wards with all narcotics and a record of doses given and the name of the person administering each dose is entered. (see Addendum E). Narcotics on the ward are checked periodically during the day to prevent misuse.

VIII. FORMULARY

A complete list of approved drugs used in the Pharmacy is maintained on a metal visible record file and the additions and deletions to approved drugs



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are carefully kept up to date. Each shelf, cupboard and drawer in the Pharmacy is numbered and the location of each drug is recorded beside each item so that it may be located quickly.

Literature and technical information is also kept on file and is frequently referred to by the medical staff.

Our Internes' Handbook lists many of the diseases commonly treated in The Hospital for Sick Children and the drugs used in their treatment. This very useful publication provides a handy reference for our resident staff. In addition, sections are also devoted to special conditions, e.g. fibrocystic disease, coeliac disease, etc. and an up to date chapter on vitamins is included.

XI. MANUFACTURING

One section of the Pharmacy is devoted to manufacturing and packaging of drugs under the supervision of the pharmacists. Many of the standard tablets and medicines are purchased in bulk and packaged in this area.

General Manufacturing includes the preparation of various solutions such as zephiran, bichloride, coloured diluted carbolic acid, soaps, formaldehyde, etc. Distilled water is also produced in large quantities. Skin and Allergy Clinics require many types of ointments and lotions to be dispensed and particular attention is given to the production of hydrocortisone ointments and creams in various combinations. Most of these



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products are packed in the various sizes required for prescription and much time and work is thereby saved.

THE CHAIRMAN: How many employees are in that section?

MR. SAGE: Two pharmacists, two non-pharmacists and a packer, supervised by a pharmacist.

THE CHAIRMAN: Would you repeat the answer to the question?

MR. SAGE: The question was?

THE CHAIRMAN: How many employees are there in this section described as manufacturing in Part IX?

MR. SAGE: There are two non-pharmacists and one packer.

THE CHAIRMAN: And how many pharmacists?

MR. SAGE: There is a supervisor and pharmacist part-time.

THE CHAIRMAN: So that is one supervising pharmacist part-time, two men full-time and one packer; is that the answer?

MR. SAGE: Yes, sir.

MR. BRYDEN: Have you any idea what percentage of the drugs supply used in the hospital would be processed in your manufacturing and packaging establishment?

MR. SAGE: In dollars probably not a great percentage, because we do not manufacture anything complicated of a compound nature. Ours is chiefly of the solution nature. Ours is not a large



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manufacturing operation, Mr. Chairman.

X. ANALYSIS

The hospital Pharmacy is not equipped to analyse the quality of drugs purchased and it is extremely doubtful whether there would be sufficient time available for this procedure even if facilities were provided. Pharmaceuticals generally are purchased from firms which fully guarantee the standards of their products. Without this guarantee it would be necessary to subject all drugs to strict laboratory control. This has not been necessary since care is taken to ensure that all suppliers do in fact operate strict controls on their own products.



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IX. ACCOUNTING

Drugs purchased or withdrawn from Main Stores are recorded in the books at cost price. In 1960 our expense for drugs, prescriptions and medicines totalled \$274,908. and represented 4.1% of our total operating expense excluding research expense. This is difficult to compare with the 1959 expense because of the change in classification of certain items in the new Canadian Hospital Accounting Manual which were previously classified as medical, surgical supplies and are now being recorded as drugs, e.g. oxygen, anaesthetic gases. Taking these two classifications in total, our expense for drugs and medical, surgical supplies increased from \$438,624. In 1959 to \$456,022. in 1960.

From January 1, 1959 the hospital has been reimbursed for In-Patient operating expenses on an all-inclusive per diem rate calculated by the Ontario Hospital Services Commission from the annual budget and adjusted to actual expense at the year end. Drugs supplied to all in-patients both private and indigent patients form part of the allowed operating expenses by the O.H.S.C. and no specific charge has been made to an account of a patient for drugs since January 1, 1959. Patients are allowed to take home drugs up to a two week supply so that their treatment will not be interrupted and these are sold to the patient at cost plus 10%. In the case of indigent patients this expense is absorbed by the hospital as a free service and is not recovered



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from the O.H.S.C. or from the municipality involved.

We maintain one pricing schedule for drugs sold to out-patients on the basis of cost plus 10%. Private out-patients and employees purchasing drugs through the Pharmacy pay this price. All drugs were supplied free to clinic patients from January 1st to September 21st, 1959 when a charge was instituted. Clinic patients are now charged the standard rate of cost plus 10% up to a maximum charge of \$2.00 per order regardless of the value dispensed. The balance of the order over the \$2.00 charge is given free to the clinic patient by the hospital.

The gross revenue from drugs dispensed to all out-patients, including the mark up of 10%, is deducted from the operating expense of the Pharmacy in calculating the amount allowed by the O.H.S.C. for in-patients and the loss between the amount actually received and the gross revenue deducted is absorbed by the hospital.

XII. SUMMARY

A review of patient days and cost of all medical, surgical supplies, drugs and medicines, while higher in 1959 than in 1958, shows no appreciable increase in 1960 over 1959 using the patient day index, although cost in dollars continues upward. From the following figures it might be assumed that it is the utilization of services in 1960, including drugs, rather than the cost of drugs that is chiefly responsible for the added expense.



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Should this attached information be read into the record, Mr. Chairman?

THE CHAIRMAN: Would you repeat that please, I was interested in looking at the brief.

MR. SAGE: At page 7 I have a lot of statistical figures, should they be read in?

THE CHAIRMAN: The reporter will have them put in. Would you explain them.

MR. SAGE: First are Patient Days for 1958, 1959 and 1960; then Total cost of drugs and medical, surgical supplies and then Per diem cost of drugs and medical, surgical supplies and then the Ontario Hospital Services Commission allowance.

	<u>1958</u>	<u>1959</u>	<u>1960</u>
Patient Days	177,941	185,637	189,663
Total cost of drugs and medical, surgical supplies (see Accounting)	\$358,333	\$438,624	\$456,022
Per diem cost of drugs, and medical, surgical supplies Total	\$2.01	\$2.36	\$2.40
O.H.S.C. In-Patient allowance (after crediting income from Out-Patients)	1.96	2.32	2.36

We believe that with an active Pharmacy Committee investigating the constituents of new drugs proffered, much can be accomplished in eliminating purchases of new "Brand names" which merely duplicate similar compounds already in use. The Pharmacist, backed by the Pharmacy Committee is permitted to substitute other compounds for Brand names if the chemical



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(see Accounting)

Per diem cost of drugs, and medical, surgical supplies	Total	\$2.01	\$2.36	\$2.70
--	-------	--------	--------	--------

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A D D E N D A (follows)



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A D D E N D A (follows)



ADDENDUM A

PHARMACY REGULATIONS

1. Out-Patient Clinic prescriptions are to be stored for two years, and then discarded.
2. All new drugs for testing, coming into the Hospital, must be approved by the Head of the Clinical Department before use.

The Pharmacy must always be advised of the names of such drugs and where they can be obtained.
3. No narcotics are to be issued from ward supplies except those issued to patients on the ward, on a signed authority.

The Emergency Department is the source of supply for narcotics for any emergency within the Hospital.
4. No medications or drugs are to be supplied free to Residents except on a prescription signed by Dr. W. H. Bain, the Physician to the Residents.
5. Directions for oral dosage of medications issued by the Pharmacy are to be written or typed on the container.
6. A supply of Tuinal capsules grains 3 is to be kept in the Nursing School office, and in the Emergency Department. These capsules can be given to parents for whom sedation is felt to be advisable.
7. No one is to be sold alcohol from the Pharmacy.

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No one is to be sold alcohol from the Pharmacy.



- It may be obtained as a prescribed medication.
8. Bulletins listing current changes in approved drugs are to be posted from time to time to keep the Pharmacy staff up to date.
 9. Residents or attending Staff are to do all writing of original prescriptions, being specific in ordering the drugs regarding the amount, the route of administration, and the total number of doses needed except as indicated in #10.b.
 - 10.a Orders for prescriptions must be made out using terms q.4.h, q.6.h., q.8.h., etc. If t.i.d. is used reference to hour is necessary. Exact hour and doses to be given 3 times a day must be written.
 - 10.b The Pharmacy Committee recommends that Nurses request all doctors to write all prescriptions when on the ward. Repeat orders can be made out by nurses. In all cases when a repeat prescription is made out by a nurse, the prescription must be marked - REPEAT.

Narcotic repeat prescriptions must be signed by the Staff Doctor or Resident.
 - 11 Regarding Pharmacy requisitions after hours, the senior resident on the service on which the orders are prescribed, shall be responsible, together with someone from the Administration, for getting these pharmaceuticals to their proper destination to the Hospital. They will sign for these drugs and signify the time they were taken from the



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Pharmacy. The senior resident on the ward where the order is prescribed may call the prescribing doctor when necessary, in order that a substitution may be made for some existing order where that specific drug, made by a particular company is not available on the ward.

12. Orders for medications to accompany patients on discharge must be written and sent to the Pharmacy, as early as possible before the time of discharge to enable the Pharmacy to have the prescription ready.
13. Hours for employee purchases at the Pharmacy wicket are:

Monday to Friday 3 p.m. to 4:30 p.m.
14. Health Unit prescriptions for employees:
These prescriptions will be dispensed during staff hours as stated in paragraph #13, except in the case of urgent scripts which will be prepared immediately or in as short a time as may be required for preparation.
15. Where a drug is ordered by its trade name, i.e. Meticorten, the Pharmacy has the option of substituting a cheaper drug of an identical chemical constitution.



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ADDENDUM B

REGULATIONS GOVERNING THE HANDLING OF NARCOTICS ON THE WARD

1. The head nurse is fully responsible for all narcotics on the ward. She, or in her absence, the charge nurse on the ward, shall participate personally in the narcotic count at least once in every 24 hours.
2. While the narcotic drawer is unlocked, the nurse must never leave the medicine room.
3. The key to the narcotic drawer is to be carried at all time by the charge nurse on the ward. At the conclusion of the period of her duty, the nurse who holds the narcotic key will hand it over to the nurse who is in charge for the next period. Together they will count all the narcotics and Seconal and enter the count and sign their names on the sheet provided in the narcotic book. This count shall be done at the changes of staff at 7:00 a.m., 3:15 p.m., and 11:15 p.m. The nurse going off duty checks to be sure the number is correct in accordance with any orders that have been filled, and the nurse coming on signs to show that she received the stated number.
4. Any discrepancy in the count is to be immediately investigated and reported to the Nursing Office. If a satisfactory explanation has not been found within 24 hours, the matter is then reported to



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- the Narcotics Division by the Administration.
5. When a tablet is contaminated or otherwise rendered useless, the space belonging to that tablet should be marked "see note A.B. or C" and an explanation written on the back page, and should be signed by the nurse concerned and witnessed by a second nurse. If the damaged tablets can be collected, they should be placed in a small envelope and returned to the Pharmacy with an explanatory note, again to be signed by the nurse concerned and witnessed by a second nurse.
- The term "wasted" is not to be used.
6. Where a partial dose of a tablet is indicated, the actual quantity administered and the discard should be entered in the same space, opposite the patient's name. One signature of the nurse administering the drug to the patient will suffice in such cases.
7. No ward may borrow a narcotic from any other ward. If something is needed which is not on the ward, it should be obtained from the Emergency Department and the order book must be taken to the Emergency Department to validate the request.
8. Narcotic books are to be sent to the Nursing Office every Wednesday morning.
9. Each narcotic record is to be signed for by the nurse in charge of the ward or department on the Narcotic Records and on the Narcotic List Record,



the Narcotics Division by the Administration.

When a tablet is contaminated or otherwise

rendered useless, the space belonging to that

tablet should be marked "see note A.B. or C."

and an explanation written on the back page,

and should be signed by the nurse concerned

and witnessed by a second nurse. If the damaged

tablets can be collected, they should be placed

in a small envelope and returned to the Pharmacy

with an explanatory note, again to be signed by

the nurse concerned and witnessed by a second

note:

The term "wasted" is not to be used.

Where a partial dose of a tablet is indicated,

the actual quantity administered and the discard

should be entered in the same space, opposite

the patient's name. One signature of the nurse

administering the drug to the patient will

suffice in such cases.

No ward may borrow a narcotic from any other ward.

If something is needed which is not on the ward,

it should be obtained from the Emergency Depart-

ment and the order book must be taken to the

Emergency Department to validate the request.

Narcotic books are to be sent to the Nursing Office

every Wednesday morning.

Each narcotic record is to be signed for by the

nurse in charge of the ward or department on the

Narcotic Records and on the Narcotic List Record,



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Sage

1960

- on arrival on the ward.
10. All lists to be held by ward or department until all stock is accounted for and then returned immediately to Pharmacy where it will be signed for on the Narcotic List Record by the Pharmacist on duty.
 11. When there is a change in staff involving the heads of wards or departments, the nurse taking over should check each Narcotic Sheet, and sign the Narcotic Record Book, thereby assuming responsibility for the narcotics on the ward or department.
 12. Requisitions to the Pharmacy for Narcotics must be signed before presentation to the Pharmacy by a medical doctor licensed to practise in the Province of Ontario.

April, 1959

Jean I Masten
Director of Nursing



on arrival on the ward.

All lists to be held by ward or department until

all stock is accounted for and then returned

immediately to Pharmacy where it will be signed

for on the Narcotic List Record by the Pharmacist

on duty.

When there is a change in staff involving the

heads of wards or departments, the nurse taking

over should check each Narcotic Sheet, and sign

the Narcotic Record Book, thereby assuming

responsibility for the narcotics on the ward or

department.

Requisitions to the Pharmacy for Narcotics must

be signed before presentation to the Pharmacy

by a medical doctor licensed to practise in the

Province of Ontario.

Jean I. Masten
Director of Nursing

1959



ROUTINE DRUG STOCK ADDENDUM C
ALSO LIST OF DRUGS STOCKED ON WARDS WHICH ARE TO BE
REORDERED ON PRESCRIPTION:

1. AMPOULES AND INJECTABLES: To be charged to ward
supplies.

Adrenalin 1 in 1,000 Steri-vial 30 cc

Atropine Hypo Tabs gr. 1/100, 1/150, 1/200.

A:T:S: (Tetanus Antitoxin)

Caffeine & Sodium Benzoate Amps

Codeine Hypo Tabs gr 1/4, 1/2 NARCOTIC

Coramine Amps. 1.5 cc

Demerol Injectable (Synonyms- Pethidine, Neperidine.)
NARCOTIC

Morphine Hypo Tabs. gr 1/6, 1/8, 1/12, 1/16,
NARCOTIC

Heparin 1 in 1000.

Old Tuberculin # 1, (1-2000) 5 cc

Old Tuberculin #2, (1-100) 1 cc

Paraldehyde Amps. 5 cc x 6

Phenobarbitone Amps. gr 3/4 x 6 (Gardenal, Pheno-
barbital)

Phenobarbitone Amps. gr 2 x 10 (Luminal, Pheno-
barbital)

Pitressin Amps. 10 units / 1 cc x 6

2. AMPOULES AND INJECTABLES: To be reordered on
prescription.

Calcium Chloride 10 cc x 10 (for 10A only)

Calcium Gluconate 10%. 10 x 10 cc (20 for 10A)



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Sage

1961

STANDARD

ROUTINE DRUG STOCK

ALSO LIST OF DRUGS STOCKED ON WARDS WHICH ARE TO BE

REORDERED ON PRESCRIPTION:

1. AMPOULES AND INJECTABLES: To be charged to ward

supplies.

Adrenalin 1 in 1,000 Steri-vial 30 cc

Atropine Hypo Tabs gr. 1/100, 1/150, 1/200.

Atropine Steri-vial 30 cc

Caffeine & Sodium Benzoate Amps

Cocaine Hypo Tabs gr 1/4, 1/2 NARCOTIC

Coramine amps. 1.5 cc

Demerol Injectable (Synonyms - Pethidine, Neperidine.)
NARCOTIC

Morphine Hypo Tabs. gr 1/6, 1/8, 1/12, 1/16,
NARCOTIC

Heparin 1 in 1000.

Old Tuberculin #1, (1-2000) 5 cc

Old Tuberculin #2, (1-100) 1 cc

Paraldehyde Amps. 5 cc x 6

Phenobarbitone Amps. gr 3/4 x 6 (Gardinal, Pheno-
barbital)

Phenobarbitone Amps. gr 2 x 10 (Luminal, Pheno-
barbital)

Pitressin Amps. 10 units \ 1 cc x 6

2. AMPOULES AND INJECTABLES: To be reordered on

prescription.

Calcium Chloride 10 cc x 10 (for 10A only)

Calcium Gluconate 10%. 10 x 10 cc (20 for 10A)



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Dilantin Sodium. 250 mgm I.V.

Glucose 50%. 50 cc x 2

Lanoxin 0.5 mgm in 2 cc x 6

Largactil 25 mgm/cc, 2 cc x 4 for 6A and 6B only

Magnesium Sulphate 1 gram in 2 cc x 4 for 5A and
5B only

Vitamin C 100 mgm in 2 cc (Cevalin) x 10. for 4A,
4C, 4D, 5C, 10A, 10B only.

Vitamin K 5 mgm in 1 cc (Synkavite) x 10 for 4A,
4C, 4D, 5C, 10A, 10B, only.

Sodium Bicarbonate 5%. 50 cc x 2 for 4C, 4D, 5D, 6C
6D, 10A, only.

ADDITIONS:

DELETIONS:

3. ANTIBIOTICS: To be charged to ward supplies

Penicillin G .Aqueous 1 million units (Crystapen)

Penicillin G .Aqueous 5 million units (Crystapen)

Penicillin Fortified, slow-rapid type.

10 dose vials, 4,000,000 units per vial

contents per 1 cc-

Procaine penicillin G 300,000 in

Crystalline Sodium penicillin '

G 100,000 iu

(synonyms, Seclopen, S. R. Penicillin etc)

Penicillin-Streptomycin combined. (Seclomycin 1/2)



ANGUS, STONCHURCH & CO. LTD.
TORONTO, ONTARIO

Dilantin Sodium. 250 mgm I.V.

Lanoxin 0.5 mgm in 2 cc x 6

Largactil 25 mgm/cc, 2 cc x 4 for 6A and 6B only
Magnesium Sulphate 1 gram in 2 cc x 4 for 5A and

5B only

Vitamin C 100 mgm in 2 cc (Cevadin) x 10. for 4A,

4C, 4D, 5C, 10A, 10B only.

Vitamin K 5 mgm in 1 cc (Synkavite) x 10 for 4A,

4C, 4D, 5C, 10A, 10B, only.

Sodium Bicarbonate 5%. 50 cc x 2 for 4C, 4D, 5D, 6C

6D, 10A, only.

DELIVERIES:

DELIVERIES:

ANTIBIOTICS: To be charged to ward supplies

Penicillin G. aqueous 1 million units (Crystapen)

Penicillin G. Aqueous 5 million units (Crystapen)

Penicillin G. Aqueous 10 million units (Crystapen)

10 dose vials, 4,000,000 units per vial

Procaine penicillin G 300,000 in

crystalline form (Crystapen)

2.100.000 in

(synonyms, Seclophen, S. R. Penicillin etc)

Penicillin-Streptomycin combined. (Seclophen 1/2)



Sage

1963

ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Streptomycin Sulphate. 1 gram (Strepolin-33)

ADDITIONS:

DELETIONS:

4 EXTERNAL DRUGS: To be charged to ward supplies

Acriflavine, Aqueous solution, 1% for 4A, 4C, 4D
5C, 10A, 10B only.

Acriflavine Emulsion for 5A, & 5B
6A & 6B
7A & 7B
7C only

Adrenalin Topical Sol. 1-1,000 x 1 fl.oz.

B.F.I. Powder. Hospital size

Buttocks paste x 16 oz

Calamine Lotion x 8 oz

Collodion U.S.P.

Compound Tincture of Benzoin. (Tr. Benz. Co.)

Friars Balsam

Ephedrine Nose Drops 1/2% Isotonic

Ephedrine Nose Drops 1% Isotonic

Hydrogen Peroxide 3% x 16 oz. (10 vol)

Gentian Violet aqueous solution 1% x 2 oz.

Hygeol x 16 oz. (concentrated)

Nivea Cream 1 lb jars

ADDITIONS:

DELETIONS:



Streptomycin Sulphate. 1 gram (Streptolin-33)

ADDITIONS:

DELETIONS:

EXTERNAL DRUGS: To be charged to ward supplies

Acriflavine, Aqueous solution, 1% for #A, #C, #D

5C, 10A, 10B only.

Acriflavine Emulsion
for 5A, & 5B
6A & 6B
7A & 7B
7C only

Adrenalin Topical Sol. 1-1,000 x 1 fl.oz.

B.F.I. Powder. Hospital size

Buttocks paste x 16 oz

Calamine Lotion x 8 oz

Collodion 10%.

Compound Tincture of Benzoin. (Tr. Benz. Co.)

Other Medicines

Ephedrine Nose Drops 1/2% Isotonic

Ephedrine Nose Drops 1% Isotonic

Hydrogen Peroxide 3% x 16 oz. (10 vol)

Gentian Violet aqueous solution 1% x 2 oz.

Hygeol x 16 oz. (concentrated)

Nivea Cream 1 lb jars

ADDITIONS:

DELETIONS:



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Phisohex x 80 oz TO ALL WARDS:

Sodium Chloride Tablets 15.5. grains x 100

Sterisol Mouthwash 22 oz

Starch Powder

Surgical Lubricant. (Lubafax and K.Y. Jelly)

Talcum Powder,

Tincture of Iodine 2 1/2%

Whiteheads Varnish

White Petrolatum

Witch Hazel x 80 oz

Zinc Oxide Ointment 1 x 2 oz for 5A, 5B.
6A, 6B.
7A, 7B.
7C.

ADDITIONS:

DELETIONS:

5. INTERNAL DRUGS: To be charged to ward supplies.

Aspirin Tablets (A.S.A.) gr 1

Aspirin Tablets (A.S.A.) gr 5

Ascorbic Acid Tablets 25 mgm and 50 mgm for
4A, 4C, 4D.
5C.
10A, 10B.

NOTE: - 50 mgm only
for 5B
6A, 6B.

A.P.C. with C (Frosst's # 222) A.P.C. with
Codeine

Cascara Aromatic



Phisohex x 80 oz TO ALL WARDS:

Sodium Chloride Tablets 15.5. grains x 100

Sterilal Mouthwash 22 oz

Surgical Lubricant. (Imbatex and K.Y. Jelly)

Talcum Powder.

Tincture of Iodine 2 1/2%

Whitehead's Varnish

White Petrolatum

Witch Hazel x 80 oz

Zinc Oxide Ointment 1 x 2 oz for 5A, 5B.
6A, 6B.
7C.

ADDITIONS:

REVISIONS:

INTERNAL DRUGS: To be charged to ward supplies.

Aspirin Tablets (A.S.A.) gr 5

Ascorbic Acid Tablets 25 mgm and 50 mgm for
10A, 10B.
NOTE: - 50 mgm only
for 5B
6A, 6B.

A.P.C. with C (Frost's # 222) A.P.C. with
Codeine

Caesars Pharmacy



Sage

1965

ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Ferrous Sulphate Tabs grs, 5 (not infant wards)

Magnesium Sulphate 50 % solution, and Crystals

Magnolax

Milk of Magnesia

Phenobarbitone Tablets. gr. 1/4, gr. 1/2. (no gr.
1/2 tabs on Infant Wards)

Phenobarbitone aqueous solution (gr. 1/8 in one
dram) for 4A, 4C, 4D, 5C, 10A, 10B

Potassium Chloride Solution gr. 15 in one dram.

Seconal Capsules gr. 3/4

Seconal Capsules gr. 1/2 for 4A, 4B, 4C
5C
9th
10B only

Sodium Bicarbonate Powder.

Sodium Bicarbonate Solution 2% for 10A, 10B.

Sodium Bicarbonate Tablets gr. 5 and gr. 10

Mist. Creta with Tr. Camph. Co. min. 5, 10, 15 in
one dram
(no min. 15 on Infant Wards)

ADDITIONS: Multivites Pellets

DELETIONS:

6. INTERNAL DRUGS: To be reordered on prescription

Aminophylline Compound Tablets 1 x 12

Bendryl Capsules 50 mgm 1 x 12 (not on Infant wards)

Benadryl Elixir 1 x 2 oz

Lanoxin Elixir (Digoxin) 1 x 2 oz for 4A, 4C, 4D,
5C
10A, 10B.



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Ferrrous Sulphate Tabs Grs. 5 (not infant wards)
Magnesium Sulphate 50 % solution, and Crystals

Magnolax

Milk of Magnesia

Phenobarbitone Tablets. gr. 1/4, gr. 1/2. (no gr.

1/2 tabs on Infant Wards)

Phenobarbitone aqueous solution (gr. 1/8 in one

gram) for #A, #C, #D. 5C, 10A, 10B

Potassium Chloride Solution gr. 15 in one gram.

Seconal Capsules gr. 3/4

Seconal Capsules gr. 1/2 for #A, #B, #C

10B only
get

Sodium Bicarbonate Powder.

Sodium Bicarbonate Solution 2% for 10A, 10B.

Sodium Bicarbonate Tablets gr. 5 and gr. 10

Mist. Creta with Tr. Camph. Co. min. 5, 10, 15 in
one gram

(no min. 15 on Infant Wards)

ADDITIONS: Multivites Pellets

DELETIONS:

INTERNAL DRUGS: To be recorded on prescription

Aminophylline Compound Tablets 1 x 12

Bendryl Capsules 50 mgm 1 x 12 (not on Infant wards)

Bendryl Elixir 1 x 2 oz

Lanoxin Elixir (Digoxin) 1 x 2 oz for #A, #C, #D,

10A, 10B.
5C



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Sage

1966

Mycostatin Suspension for 4A, 4C, 4D.

5C

10A, 10B.

Trulfa Suspension 2 x 2 oz

Dilantin Infatabs 50 mgm 1 x 10 for 6C, 6D.

5D.

9th.

Kaopectate 2 x 4 oz for 6A, 6B.

ADDITIONS: Digoxin Tablets 12 x 0.25 mgm
(not on Infant wards)

DELETIONS:



Macostatin Suspension for #A, #C, #D.

10A, 10B.

Tritia Suspension 2 x 2 oz

Dilantin Infants 50 mgm 1 x 10 for 6C, 6D.
5D.

Kapocetate 2 x 4 oz for 6A, 6B.

ADDITIONS: Digoxin Tablets 12 x 0.25 mgm
(not on Infant wards)

REMARKS:



7. LIQUIDS AND SOLUTIONS: To be charged to ward supplies

Acetic Acid Solution 2½% and 10%

Acetone

Adhesive remover

Alcohol 70% (S.V.R. Spirit Vini Rect.)

Cetabrom Aqueous 1%

Dettol Antiseptic

Dettol Hand Lotion

Detergicide Aqueous 1-1,000

Distilled Water

Green Soap Pure

Green Soap Solution

Hibitane Aqueous Solution 1-5,000

Hibitane Aqueous Solution 1-2,000

Hibitane Alcoholic Solution 1-200

Hibitane Aqueous Solution 1-2,000

(coloured) for use with Metallic
objects, containing antirusting
agent. Suitable for use as "Safety
Pin" solution, etc.

Liquid Paraffin

Lysol Pure

Lysol Solution 2%

Methyl Hydrate

Olive Oil

Potassium Permanganate Aqueous 1-1,000

Rubbing Alcohol

Thermometer Solution (Tincture of Iodine



ANGUS STONEHOUSE & CO. LTD.
TORONTO, CANADA

Page

1967

LIQUIDS AND SOLUTIONS: To be charged to Ward

Supplies

Acetic Acid Solution 2% and 10%

Adhesive remover

Alcohol 70% (S.V.R. Spirit Vini Rect.)

Cetabrom Aqueous 1%

Dettol Antiseptic

Dettol Hand Lotion

Detergicide Aqueous 1-1,000

Distilled Water

Green Soap Pure

Green Soap Solution

Hibitane Aqueous Solution 1-5,000

Hibitane Aqueous Solution 1-2,000

Hibitane Alcoholic Solution 1-200

Hibitane Aqueous Solution 1-2,000

(coloured) for use with Metallic

objects, containing antirusting

agent. Suitable for use as "Safety

Pin" solution, etc.

Ispol solution

Ispol 10%

Ispol Solution 2%

Methyl Hydrate

Olive oil

Potassium Permanganate Aqueous 1-1,000

Rubbing Alcohol

Thermometer Solution (Tincture of Iodine)



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Sage

1968

and Alcohol)

Zephiran Aqueous Solution 1-1,000

Zephiran Tincture (coloured) 1-1,000

ADDITIONS:

DELETIONS:

8. MISCELLANEOUS: To be charged to ward supplies

Airkem with Wick

Airkem Mist (Spraypak)

Dixie Cups

Ether Commercial

Glassware

Haemosol

Orvus or Drench

Straws

Tooth Powder

ADDITIONS:

DELETIONS:

9. OPHTHALMIC DRUGS: To be charged to ward supplies

Atropine Ophthalmic Ointment 1%

Atropine Eyedrops 1% and 2%

Homatropine Eyedrops 1% and 2%

Neosynephrine Drops (Monodrops) 10%

Polysporin Ophthalmic Oint. for 10A, 1CB



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

288

1968

and Alcohol)

Zephiran Aqueous Solution 1-1,000

Zephiran Tincture (alcohol) 1-1,000

ADDITIONS:

ADDITIONS:

8. MISCELLANEOUS: To be charged to ward supplies

Alkermid with Wick

Alkermid with Wick (alcohol)

Alkermid with Wick

Alkermid with Wick

Glassware

Hammer

Orals or Drench

Orals

Tooth Powder

ADDITIONS:

ADDITIONS:

9. OPHTHALMIC DRUGS: To be charged to ward supplies

Atropine Ophthalmic Ointment 1%

Atropine Eye Drops 1% and 2%

Homatropine Eye Drops 1% and 2%

Neosynephrine Drops (Monodrops) 10%

Polysporin Ophthalmic Oint. for 10A, 1CB



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Sage

1969

ADDITIONS:

DELETIONS:

10. RECTAL DRUGS: To be charged to ward supplies

Fleet Enema

Glycerin Suppositories

Nembutal Suppositories gr. $\frac{1}{2}$

Nembutal Suppositories gr. 1

RECTAL DRUGS: To be reordered on prescription

Aminophylline Suppositories gr. $3\frac{3}{4}$ x
12 (not for Infant Wards)

Aminophylline Suppositories gr. 1 for 4A,
4C, 4D. 5C. 10A, 10B.

Gravol Suppositories 50 mgm x 12 for 7B
only.

ADDITIONS:

DELETIONS:

11. SPECIAL DRUGS ON WARDS 7C and 7D only. To be
charged to ward supplies

I.N.H. Tablets 50 mgm x 100

P.A.S. Elixir x 8 oz

P.A.S. Tablets 500 mgm x 100



ADDITIONS:

DELETIONS:

10. RECTAL DRUGS: To be charged to ward supplies

Fleet Enema

Glycerin Suppositories

Nembutal Suppositories gr. $\frac{1}{2}$

Nembutal Suppositories gr. 1

RECTAL DRUGS: To be reordered on prescription

Aminophylline Suppositories gr. $3\frac{3}{4}$ x

12 (not for Infant Wards)

Aminophylline Suppositories gr. 1 for 4A,

gr. 1 for 4B, 1 for 4C, 1 for 4D,

Gravol Suppositories 50 mgm x 12 for 7B

only.

ADDITIONS:

DELETIONS:

11. SPECIAL DRUGS ON WARDS 7C and 7D only. To be

charged to ward supplies

I.N.H. Tablets 50 mgm x 100

P.A.S. Tablets 500 mgm x 100

P.A.S. Tablets 500 mgm x 100



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Sage

1970

Sulphathiazole Cream 30% x 4 oz.

SPECIAL DRUGS ON 7C and 7D only. To be reordered
on prescription

Adrenal Cortical Extract x 1

Amigen 3 x 250 cc

Bacitracin Parenteral 10,000 Units x 3

Gantrisin Amps 2 grams in 5 cc x 25

Philadelphia Serum x 1

Sulphadiazine Tablets 0.5 gram x 50

Darrow's Solution 250 cc x 3

Streptomycin Amp. Intrathecal 50-mgm x 1

ADDITIONS:

DELETIONS:

12. SPECIAL DRUGS ON 7A and 7B only. To be charged
to ward supplies

Ophthalmic Solutions

Butyn 2%

Eserine $\frac{1}{4}$ %

Fluorescein 2%

Holocaine 1%

Homatropine 5%

Pilocarpine 1% and 2%

Sulfacetamide 10% and 30%

(Sulamyd)

Oxycel Cotton Type



Sulphathiazole Cream 30% x 4 oz.

SPECIAL DRUGS ON 7C and 7D only. To be re-ordered

on prescription

Adrenal Cortical Extract x 1

Amigen 3 x 250 cc

Bactracin Parenteral 10,000 Units x 3

Gentristin Amps 2 grams in 5 cc x 25

Philadelphia Serum x 1

Sulphadiazine Tablets 0.5 gram x 50

Darrow's Solution 250 cc x 3

Streptomycin Amp. Intrathecal 50 mgm x 1

ADDITION:

REPLACEMENT:

12. SPECIAL DRUGS ON 7A and 7B only. To be charged

to ward supplies

Ophthalmic Solutions

Butyn 2%

Beserine 1%

Fluorescein 2%

Holocaine 1%

Homatropine 2%

Pilocarpine 1% and 2%

Sulfacetamide 10% and 30%

(continued)

Oxycel Cotton Type



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Sage

1971

Oxycel Gauze Type

Tuamine Solution 1%

SPECIAL DRUGS ON 7A and 7B only. To be reordered
on prescription

Diamox Tablets 2 x boxes of 6 for 7A

250 mgm

Gantrisin Tablets 2 x boxes of 12 for

7A 0.5 gram

Neosynephrine Solution $\frac{1}{4}\%$ and $\frac{1}{2}\%$ 2

fluid drams x 2 for 7B

Statimo Amps 1cc for 7B 6 amps

ADDITIONS: Neosporin Ophthalmic Oint.

$\frac{1}{8}$ oz 7A & 7B only

DELETIONS:

ADDENDUM D

EMERGENCY DRUG STOCK

The emergency drug stock contains the
following items:

Achromycin Pediatric Drops	10 cc.	1
Achromycin Oral Syrup	60 cc.	2
Achromycin Intramuscular	250 mgm.	1
Achromycin Intravenous	250 mgm.	1
A.C.T.H.	25 U.	1
Bicillin 600 L.A. Tubex		2
Chloromycetin Palmitate	60 cc.	4



Oxygel Gauze Type

Tumaine Solution 1%

SPECIAL DRUGS ON VA and VB only. To be reordered

on prescription

Diamox Tablets 2 x boxes of 6 for VA

250 mgm

Gentristin Tablets 2 x boxes of 12 for

VA 0.5 gram

Neosynephrine Solution 1% and 1/2% 2

fluid grams x 2 for VB

Statim Amps 1cc for VB 6 amps

ADDITIONS: Neosporin Ophthalmic Oint.

1/8 oz VA & VB only

DELETIONS:

APPENDIX D

EMERGENCY DRUG STOCK

The emergency drug stock contains the

following items:

1	10 cc.	Achromycin Pediatric Drops
2	60 cc.	Achromycin Oral Syrup
1	250 mgm.	Achromycin Intramuscular
1	250 mgm.	Achromycin Intravenous
1	250 mgm.	Achromycin Intravenous
2		Bicillin 600 I.U. Tubex
4	60 cc.	Chloromycetin Palmitate



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Sage

1972

Chloromycetin I.M. & I.V.	1 Gm.	4
Cortisone Tablets	25 mgm.	12
Crystamycin		6
Erythrocin I.M. & I.V.	1 Gm.	1
Ilosone Pediatric Drops	10 cc.	1
Ilosone Pediatric Susp.	40 cc.	2
Ilotycin I.V.	250 mgm.	2
Kaomycin	2 oz.	1
Potassium Chloride 20 mleq.	10 cc.	1
Potassium Chloride 40 mleq.	20 cc.	1
Prednisone Tablets	5 mgm.	12
Solu-Cortef	100 mgm.	2

The above drugs are to be kept in a locked cupboard or drawer.

These emergency drugs are for the use of in-patients on the ward only. A prescription for each drug issued from the emergency stock is to be sent to the Pharmacy the following day. The prescription must state that the drug was issued from emergency stock.

A drug issued from this emergency stock will be replaced by the Pharmacy when the prescription is received in the Pharmacy.

Any drug that is missing from this emergency stock is to be reported by the nurse in charge of the ward to the Hospital Controller.

The emergency drug stock is to be used



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, CANADA

Chloromycetin I.M. & I.V.		
Chlormycetin Tablets		
Crystamycin		6
Erythrocine I.M. & I.V.	1 Gm.	1
Ilosone Pediatric Drops	10 cc.	1
Ilosone Tablets		
Iloxylin I.V.	250 mgm.	2
Potassium Chloride 20 mied.	10 cc.	1
Potassium Chloride 40 mied.	20 cc.	1
Prednisone Tablets	5 mgm.	12
Solu-Cortef	100 mgm.	2

The above drugs are to be kept in a

locked cupboard or drawer.

These emergency drugs are for the use of in-patients on the ward only. A prescription for each drug issued from the emergency stock is to be sent to the Pharmacy the following day. The prescription must state that the drug was issued from emergency stock.

A drug issued from this emergency stock will be replaced by the Pharmacy when the prescription is received in the Pharmacy.

Any drug that is missing from this emergency stock is to be reported by the nurse in charge of the ward to the Hospital Controller.

The emergency drug stock is to be used



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Sage

1973

only when the pharmacy department is closed.

Received by.....

Date.....

(Addendum E - Narcotic Record follows)

1911

1912

ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO



only when the pharmacy department is closed.

Received

Date.....

(Signature of ...)

1974

Page 27

ADDENDUM E

1 HOSPITAL FOR SICK CHILDREN
NARCOTIC RECORD

SHEET NO. 282A

N. P. 158

EXAM TO TABLETS

AMOUNT 68 DATE 11.1.61 NAME OF DRUG Codeine Phosphate

RECEIVED BY [Signature] STRENGTH UNIT Grain 1

ISSUED BY M. [Signature] 7 E. [Signature] AMOUNT 12 TABLETS

DATE	TIME	PATIENT'S NAME	DOSE TABLETS	BALANCE TABLETS	NAME OF DOCTOR	SIGNATURE OF NURSE
Jan 1/61	7 ¹⁵	Heather Clarke	55	10	Dr. [Signature]	J. [Signature]
Jan 1/61	7 ¹⁵	Heather Clarke	55	9	Dr. [Signature]	J. [Signature]
Jan 1/61	10 ¹⁵	Heather Clarke	55	8	Dr. [Signature]	J. [Signature]
Jan 1/61	10 ¹⁵	Heather Clarke	55	7	Dr. [Signature]	J. [Signature]
Jan 2/61	10am	Heather Clarke	55	6	Dr. [Signature]	J. [Signature]
Jan 24/61	7am	Lilly Makinowski	gr 55	6	Dr. Salter	B. [Signature]
Jan 24/61	7am	Lilly Makinowski	gr 55	5	Dr. Salter	B. [Signature]
Jan 24/61	12 ³⁰	Mina Delle	gr 55	4	Dr. [Signature]	J. [Signature]
Jan 24/61	12 ³⁰	Mina Delle	gr 55	3	Dr. [Signature]	J. [Signature]
Jan 24/61	12 ³⁰	Mina Delle	gr 55	2	Dr. [Signature]	J. [Signature]
Jan 24/61	9 ³⁰	Lilly Makinowski	gr 55	1	Dr. [Signature]	J. [Signature]
Jan 24/61	3 ³⁰	Lilly Makinowski	gr 55	0	Dr. [Signature]	J. [Signature]
Jan 24/61	2pm	Lilly Makinowski	gr 55	0	Dr. [Signature]	J. [Signature]
12 tablets Codeine gr 1/2 given accounted for						
mlat						

THIS SHEET WHEN COMPLETED MUST BE RETURNED TO THE PHARMACY

21777 100-3820
100-3820 100-3820 100-3820 100-3820
100-3820 100-3820 100-3820 100-3820

PATIENT'S NAME	DATE	TIME	TEMP.	PULSE	BLOOD PRESSURE	RESPIRATIONS	WEIGHT	HEIGHT	DIET	DRUGS	NOTES
John Doe	10/1/23	8:00 AM	98.6	72	120/80	18	150	5'10"	Regular	Aspirin	Headache
Jane Smith	10/1/23	9:00 AM	98.4	68	110/70	16	120	5'5"	Regular	None	Well
Robert Johnson	10/1/23	10:00 AM	98.8	80	130/90	20	180	6'0"	Regular	Insulin	Diabetes
Mary White	10/1/23	11:00 AM	98.2	60	100/60	14	110	5'3"	Regular	None	Well
James Brown	10/1/23	12:00 PM	98.5	75	120/80	18	160	5'8"	Regular	Aspirin	Headache
Elizabeth Green	10/1/23	1:00 PM	98.7	85	130/90	20	170	5'7"	Regular	None	Well
William Black	10/1/23	2:00 PM	98.3	70	110/70	16	140	5'6"	Regular	None	Well
Patricia Gray	10/1/23	3:00 PM	98.6	72	120/80	18	130	5'4"	Regular	Aspirin	Headache
Charles King	10/1/23	4:00 PM	98.4	68	110/70	16	150	5'9"	Regular	None	Well
Anna Lee	10/1/23	5:00 PM	98.5	75	120/80	18	120	5'5"	Regular	None	Well
Thomas Hall	10/1/23	6:00 PM	98.7	80	130/90	20	160	5'8"	Regular	Aspirin	Headache
Elizabeth Scott	10/1/23	7:00 PM	98.2	60	100/60	14	110	5'3"	Regular	None	Well
William Adams	10/1/23	8:00 PM	98.6	72	120/80	18	150	5'9"	Regular	Aspirin	Headache
Patricia Baker	10/1/23	9:00 PM	98.4	68	110/70	16	120	5'5"	Regular	None	Well
Charles Clark	10/1/23	10:00 PM	98.8	80	130/90	20	180	6'0"	Regular	Insulin	Diabetes
Anna Evans	10/1/23	11:00 PM	98.2	60	100/60	14	110	5'3"	Regular	None	Well
Thomas Foster	10/1/23	12:00 AM	98.5	75	120/80	18	160	5'8"	Regular	Aspirin	Headache
Elizabeth Gibson	10/1/23	1:00 AM	98.7	85	130/90	20	170	5'7"	Regular	None	Well
William Harris	10/1/23	2:00 AM	98.3	70	110/70	16	140	5'6"	Regular	None	Well
Patricia Ives	10/1/23	3:00 AM	98.6	72	120/80	18	130	5'4"	Regular	Aspirin	Headache
Charles Jones	10/1/23	4:00 AM	98.4	68	110/70	16	150	5'9"	Regular	None	Well
Anna Kelly	10/1/23	5:00 AM	98.5	75	120/80	18	120	5'5"	Regular	None	Well
Thomas Lewis	10/1/23	6:00 AM	98.7	80	130/90	20	160	5'8"	Regular	Aspirin	Headache
Elizabeth Martin	10/1/23	7:00 AM	98.2	60	100/60	14	110	5'3"	Regular	None	Well
William Nelson	10/1/23	8:00 AM	98.6	72	120/80	18	150	5'9"	Regular	Aspirin	Headache
Patricia Olsen	10/1/23	9:00 AM	98.4	68	110/70	16	120	5'5"	Regular	None	Well
Charles Parker	10/1/23	10:00 AM	98.8	80	130/90	20	180	6'0"	Regular	Insulin	Diabetes
Anna Quinn	10/1/23	11:00 AM	98.2	60	100/60	14	110	5'3"	Regular	None	Well
Thomas Reed	10/1/23	12:00 PM	98.5	75	120/80	18	160	5'8"	Regular	Aspirin	Headache
Elizabeth Scott	10/1/23	1:00 PM	98.7	85	130/90	20	170	5'7"	Regular	None	Well
William Taylor	10/1/23	2:00 PM	98.3	70	110/70	16	140	5'6"	Regular	None	Well
Patricia Underhill	10/1/23	3:00 PM	98.6	72	120/80	18	130	5'4"	Regular	Aspirin	Headache
Charles Vance	10/1/23	4:00 PM	98.4	68	110/70	16	150	5'9"	Regular	None	Well
Anna Ward	10/1/23	5:00 PM	98.5	75	120/80	18	120	5'5"	Regular	None	Well

1975

ADDENDUM E

Page 28

FORM 78-44-50

HOSPITAL FOR SICK CHILDREN

NARCOTIC RECORD

SHEET NO. 28/0

STERILE SOLUTION

WORD 5 C D DATE 13/61 NAME OF DRUG Demerol HClRECEIVED [Signature] STRENGTH UNIT 50mgm per ccISSUED BY N. B. Jones AMOUNT 6 x 1 cc

DATE	TIME	PATIENT'S NAME	DOSE	REMARKS	NAME OF DOCTOR	SIGNATURE OF NURSE
12-1-61	3:00	David Hanks	20mg	5	Dr. Smith	[Signature]
		discarded	20mg		Dr. Smith	[Signature]
6-2-61	11:30	discarded	50mg	4	Dr. Smith	[Signature]
6-2-61	11:30	discarded	50mg		Dr. Smith	[Signature]
6-2-61	11:30	discarded	40mg	3	Dr. Smith	[Signature]
6-2-61	11:30	discarded	10mg		Dr. Smith	[Signature]
6-2-61	11:30	G. Jackson	20mg	2	Dr. Smith	[Signature]
6-2-61	11:30	G. Jackson	20mg		Dr. Smith	[Signature]
6-2-61	11:30	H. King	20mg	1	Dr. Smith	[Signature]
6-2-61	11:30	H. King	20mg	Discarded	Dr. Smith	[Signature]
6-2-61	11:30	B. Robinson	40mg	5	Dr. Smith	[Signature]
6-2-61	11:30	Discarded	10mg		Dr. Smith	[Signature]

13



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Sage

1976

ADDENDUM F

LIST OF SUPPLIES TO BE ORDERED FROM HOSPITAL STORES

A.

ACETIC ACID GLACIAL GAL

ACETONE GAL

ADHESIVE REMOVER GAL

AIRKEM GAL

ALCOHOL 95% GAL

B.

BENADRYL ELIXIR 80 oz

BENYLIN EXPECTORANT 80 oz

BOTTLE BRUSHES

C.

CAMPHORATED CHALK lbs

CARBOLIC ACID (PHENOL) GAL

CHLOROMYCETIN PALMITATE 24 x 2 oz

CHLOROMYCETIN SUCCINATE 200 x 1g

CLINITEST TABS 12 x 100

COLLODION GAL

COTTON WOOL lb

CRYSTAPEN 1 MILLION U 10's

CRYSTAPEN 5 MILLION U 10's

D.

DARROW'S SOL. 250 cc C/S

DETTOL ANTISEPTIC GAL

DETTOL HAND LOTION GAL

DRENCH OR ORVUS

DROPPERS STRAIGHT

DROPPERS BALL POINT



APPENDIX B

LIST OF SUPPLIES TO BE ORDERED FROM HOSPITAL STORES

A.

ACETIC ACID GLACIAL GAL

ALCOHOL 95% GAL

ALCOHOL 70% GAL

ALCOHOL 40% GAL

ALCOHOL 25% GAL

ANTISEPTIC SOLUTION 80 oz

ANTISEPTIC SOLUTION 80 oz

ANTISEPTIC SOLUTION

CAMPHORATED CHALK lbs

CARBOLIC ACID (PHENOL) GAL

CHLOROMYCEIN PALMITATE 100 x 1/2 oz

CHLOROMYCEIN SUCCINATE 100 x 1/2 oz

CHLOROMYCEIN 100 x 1/2 oz

COTTON WOOL GAL

CRYSTAL 1 MILLION U lbs

CRYSTAL 5 MILLION U lbs

DARROW'S SOL. 250 cc

EUCALYPTI EXTRACT GAL

EUCALYPTI EXTRACT GAL

FRENCH OR ORANGE

FRENCH ORANGE

FRENCH ORANGE



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Sage

1977

E.

ETHER COMMERCIAL	lbs
ETHER SQUIBB	lb
ETHYL CHLORIDE	100 g

F.

FER-IN-SOL	15 cc x C/S
FER-IN-SOL	50 cc x C/S
FLEET ENEMA	C/S
FORMALDEHYDE	GAL
FORPEN LIQ 400/M U	12 x 60 cc
FORPEN TABS 400/M U	12 x 100

G.

GANTRISIN PED SUSPENSION	80 oz
GANTRISIN TABS 0.5 gm	1000
GLYCERIN	GAL
GREEN SOAP PURE	GAL

H.

HAEMOSOL	
HARE LIP FEEDERS	
HYDROGEN PEROXIDE 3%	1b
HYGEOL	GAL
HYLENTA LIQ 250/M U	12 x 60 cc

I. J.

JOHNSON'S BABY POWDER	DOZ
-----------------------	-----

K. L.

LEDERPLEX	12 oz C/S
LINISYL	80 oz
LIQUID PARAFFIN	80 oz
LYSOL	GAL



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Sage

1978

M.

MAGNESIUM SULFATE	lbs
MAGNOLAX	20 oz x C/S
MEDICINE GLASSES 1 oz	C/S
METHYL HYD	GAL
MILK OF MAGNESIA	GAL
MYSOLINE TABS 0.5 g	1000

N.

NOVAHISTINE ELIXIR	80 oz
--------------------	-------

O.

OINTMENT PADS	
OINTMENT TINS $\frac{1}{2}$, 1, 2, 4, 8 oz	
OLIVE OIL	GAL
OL PERCOMORPH	10 cc x C/S
OL PERCOMORPH	50 cc x C/S
OL PERCOMORPH CAPS 250	C/S
OSTOGEN A c C 30 cc	C/S
ORVUS OR DRENCH	

P.

PAPER BAGS	1, 3, 5, 10 lb
PARAMETTES SYR 16 oz	C/S
PARAMETTES TABS 100	C/S
PHENOL LIQ (CARBOLIC AcO)	GAL
PHISOHEX 5 oz	C/S
PHISOHEX	GAL
PILL BOXES, WHITE SLIDE #	178 $\frac{1}{2}$
POLYTOL LIQ 60 cc	12
POLY-VI-SOL 15 cc	C/S
POLY-VI-SOL 50 cc	C/S



ANGUS, STONEHOUSE & CO. LTD.
LONDON, ENGLAND

2015

1978

M.

MAGNESIUM SULFATE 1lb
MAGNOLAX 50 oz x 6/2
MEDICINE GLASSES 1 oz 6/2
METHYL HYD GAL
MILK OF MAGNESIA GAL
MYSOLINE TABS 0.5 g 1000

N.

NOVARTINE ELIXIR 80 oz

O.

ointment pads
ointment tins 1/2, 1, 2, 4, 8 oz
OLIVE OIL GAL
OL PERCOMORPH 10 cc x 6/2
OL PERCOMORPH 50 cc x 6/2
OL PERCOMORPH CAPS 250 6/4
OSTOGEN A c 30 cc 6/8
ORVUS OR DRENCH

P.

PAPER BAGS 1, 3, 5, 10 lb
PARAMETTES SYR 16 oz 6/2
PARAMETTES TABS 100 6/2
PHENOL LIQ (CARBOLIC ACID) GAL
PHISOHEX 5 oz 6/2
PHISOHEX GAL
PILL BOXES, WHITE SLIDE # 178 1/2
POLYTOL LIQ 60 cc 15
POLY-VI-SOL 15 cc 6/2
POLY-VI-SOL 50 cc 6/2



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Sage

1979

Q. R. S.

SEIDLITZ POWDER BOXES WHITE	
SECLOPEN 4,000,000 U	10's
SOD BICARB	1b
STERISOL MOUTHWASH 22 oz	C/S
SULFADIAZINE TABS 0.5 gm	5/M
SULFADINE SUSPENSION	80 oz

T.

TRULFA SUSPENSION	80 oz
TRULFAZINE SUSPENSION	80 oz
TRI-VI-SOL 15 cc	C/S
TRI-VI-SOL 50 cc	C/S

W. X. Y. Z.

WITCH HAZEL	GAL
ZEPHIRAN CONCENTRATE	GAL

BOTTLES, JARS and VIALS ETC. TO BE OBTAINED FROM STORES

BOTTLES

FLINT SQUARES	1 oz
	2 oz
	4 oz
KING OVALS	1 oz
	2 oz
	3 oz
	4 oz
	6 oz
	8 oz
	16 oz



W. X. Y. Z.

STERILIZED POWDER BOTTLES WITH

SCALOPEIN 4,000,000 U 10's

SOD BICARB 12

STERISOL MOUTHWASH 25 oz 6/2

SULFADIAZINE TABS 0.5 gm 5/M

SULFADIAZINE SUSPENSION 80 oz

T.

TRULFA SUSPENSION 80 oz

TRULFAZINE SUSPENSION 80 oz

TRI-VI-SOL 15 cc 6/2

TRI-VI-SOL 50 cc 6/2

W. X. Y. Z.

WITCH HAZEL GAL

ZEPTIN W CONCENTRATE

BOTTLES, TABS AND VIALS ETC. TO BE OBTAINED FROM STORES

BOTTLES

FLINT SQUARES 1 oz

2 oz

4 oz

1 oz

KING OVALS

2 oz

3 oz

4 oz

6 oz

8 oz

16 oz



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Sage

1980

MONTREAL BLAKES	32 oz
	16 oz
WINCHESTERS	
GREEN SOAP BOTTS	80 oz
ALCOHOL	8 oz
JARS	
VASELINE	2 oz
	4 oz
	8 oz
VIALS, PLASTIC	3 dr
	9 dr
	14 dr
	16 dr
BAKELITE CAPS FOR KING OVALS	
$\frac{1}{2}$ - 1 oz	18 mm
2 - 3 oz	20 mm
4 oz	22 mm
6 - 8 oz	24 mm
12 - 16 oz	28 mm
80 oz	33 mm
METAL CAPS FOR JARS	2 oz GROSS
	4 oz GROSS



ANGUS, STONEHOUSE & CO., LTD.
TORONTO, ONTARIO

STANDARD PRICES

1934

1933

WINCHES

80 oz

GREEN SOAP BOTTLERS

8 oz

ALCOHOL

JARS

5 oz

VASELINE

4 oz

8 oz

3 dr

VIALS, PLASTIC

9 dr

14 dr

16 dr

BAKELITE CAPS FOR KING OVALS

18 mm

$\frac{1}{2}$ - 1 oz

20 mm

2 - 3 oz

22 mm

4 oz

24 mm

6 - 8 oz

26 mm

12 - 16 oz

33 mm

80 oz

GROSS

2 oz

METAL CAPS FOR JARS

1934



THE CHAIRMAN: In your last paragraph on page 8 -- what are your qualifications, sir? Are you a doctor?

MR. SAGE: No sir.

THE CHAIRMAN: Pharmacist?

MR. SAGE: I am an accountant by profession.

THE CHAIRMAN: It is rather important. You are in the administrative field of hospital operation?

MR. SAGE: Yes sir, have been for eleven years, nearly eleven years.

THE CHAIRMAN: I think your last statement on page 8 is rather significant because of its relationship to the field of doctors and pharmacists. I take it you are speaking as a layman?

MR. SAGE: That is right, but with considerable knowledge over the past 11 years in trying to obtain this information for the administrative standpoint. We can support it with the advice of a group of doctors. I cannot speak too highly of the men in our hospital on this Pharmacy Committee, which has five doctors on it.

THE CHAIRMAN: I think we are getting down to the real root of some of the problems that face this Committee in your last paragraph on page 8 when you as a layman and as an experienced operator -- I say that sincerely -- as an experience operator in your own words for 11 years, you make the statement that you make there. Do you do that with the support of the medical profession or on your own behalf?

MR. SAGE: Certainly with the support of



THE CHAIRMAN: In your last paragraph on

page 8 -- what are your qualifications, sir? Are you

a doctor?

MR. SAGE: No sir.

THE CHAIRMAN: Pharmacist?

MR. SAGE: I am an accountant by profession

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Do you do that with the support of the medical profession

or on your own behalf?

MR. SAGE: Certainly with the support of



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Sage

1982

the medical members of the Pharmacy Committee.

THE CHAIRMAN: Could you give the names, please?

MR. SAGE: The names -- I don't know whether I can remember their names. The Chairman is Smith and there is a representative from the Medical Department, which is Pediatrics in the hospital, a representative from the Medical Department which is known as pediatrics in the Children's Hospital; a representative from Surgery; a representative from the Department of Anaesthesia, a representative from the Department of Ear, Nose and Throat, a representative from the Department of Eye Surgery -- is that five? Those are the doctors who sit on the Pharmacy Committee together with our assistant director and Chief pharmacist, purchasing agent and director of nursing.

MR. BRYDEN: Would it be fair to assume, Mr. Sage, that the last paragraph 8 is a statement of hospital policy? When you present this in your brief are you now expressing a hospital policy?

MR. SAGE: This is hospital policy. I will be glad to read it again. It says: "The pharmacist, backed by the Pharmacy Committee is permitted to substitute other compounds for brand names if the chemical components or constituents are similar and are produced by a reputable company". This is hospital policy.

MR. BRYDEN: This is a policy that was developed by your Pharmacy Committee?

MR. SAGE: Yes.



the medical members of the Pharmacy Committee.

THE CHAIRMAN: Could you give the names,

MR. SAGE: The names -- I don't know whether

I can remember their names. The Chairman is Smith and

there is a representative from the Medical Department,

which is Pediatrics in the hospital, a representative

from the Medical Department which is known as Pediatrics

in the Children's Hospital; a representative from Surgery;

a representative from the Department of Anaesthesia, a

representative from the Department of Ear, Nose and

Throat, a representative from the Department of Eye

Surgery -- is that five? Those are the doctors who sit

on the Pharmacy Committee together with our assistant

director and Chief Pharmacist, purchasing agent and

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components or constituents are similar and are produced

by a reputable company". This is hospital policy.

MR. BRYDEN: This is a policy that was

developed by your Pharmacy Committee?

MR. SAGE: Yes.



MR. BRYDEN: And has been approved by whatever authority...

MR. SAGE: That is right, the Medical Advisory Committee and ultimately the trustees.

MR. BRYDEN: Would you be in a position to give any breakdown, any estimate as to the breakdown of drugs that you requisition under chemical names and the proportion of brand names that your pharmacy requisitions?

MR. SAGE: I don't think there is any large quantity. Excuse me a moment.

THE CHAIRMAN: Just a moment, please. Let the witness give his answer from his experience, and then we will be pleased to hear from you later.

MR. SAGE: I would say a very minor quantity are purchase specifically under their generic names. Of course, with a brand name, they also have the generic name on the label



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are purchased specifically under their generic names. Of

course, with a brand name, they also have the generic

name on the label.



MR. PRICE: Mr. Chairman most of them are ordered by brand rather than by generic name.

THE CHAIRMAN: That would appear to be the case.

MR. PRICE: Is that correct?

MR. SAGE: I think that is mostly correct, yes.

MR. PRICE: I would have thought from this paragraph that it might have been reversed, that you might be buying by generic terms rather than by brand?

MR. SAGE: No, that was not intended to be conveyed. What was intended to be conveyed there was that you just don't buy every new brand name that comes on the market because it's a different name; compounds or components are the same. We are satisfied with the brand name that we are using, we continue to use that.

THE CHAIRMAN: Mr. Sage who determines the purchasing policy of your hospital? You? Do you?

MR. SAGE: In respect to drugs?

THE CHAIRMAN: Yes. That is what we are talking about, drugs.

MR. SAGE: You said purchasing policy. The Pharmacy Committee passes on all new drugs.

THE CHAIRMAN: You don't yourself?

MR. SAGE: No.

THE CHAIRMAN: Now who is the chairman of that Committee?



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THE CHAIRMAN: Mr. Sage who determines

the purchasing policy of your hospital? You? Do you?

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THE CHAIRMAN: Yes. That is what we are

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THE CHAIRMAN: You don't yourself?

MR. SAGE: No.

THE CHAIRMAN: Now who is the chairman

of that Committee?



MR. SAGE: Dr. Code Smith.

THE CHAIRMAN: Is he here today?

MR. SAGE: No sir, he isn't.

THE CHAIRMAN: Who are the other members of the Committee?

MR. SAGE: I would have to get them for you. I can't recall by memory.

THE CHAIRMAN: So whatever you say about your policy is hearsay, is that right?

MR. SAGE: Well I have sat on the Committee.

THE CHAIRMAN: It's hearsay.

MR. SAGE: It's in Addendum A.

THE CHAIRMAN: Just a minute now.

MR. SAGE: I don't understand your meaning of the word "hearsay".

THE CHAIRMAN: You are only repeating what someone else has told you. That is hearsay.

MR. SAGE: Even if it's in the record?

THE CHAIRMAN: Yes.

MR. SAGE: Yes.

THE CHAIRMAN: You don't determine the policy do you Mr. Sage?

MR. SAGE: No sir, I don't.

THE CHAIRMAN: Or do you?

MR. SAGE: No, I don't.

MR. WREN: Mr. Chairman he has already told us ---

THE CHAIRMAN: That is what I am getting



MR. SAGE: Dr. Gode Smith.

THE CHAIRMAN: Is he here today?

MR. SAGE: No sir, he isn't.

THE CHAIRMAN: Who are the other members

of the Committee?

MR. SAGE: I would have to put them for

you. I can't recall by memory.

THE CHAIRMAN: So whatever you say, that

your policy is hearsay, is that right?

MR. SAGE: Well I have not on the subject-

THE CHAIRMAN: It's hearsay.

MR. SAGE: There is nothing in it.

THE CHAIRMAN: Just a minute now.

MR. SAGE: I don't understand your

meaning of the word "hearsay".

THE CHAIRMAN: You are only repeating

what someone else has told you. That is hearsay.

MR. SAGE: Even if it's in the record?

THE CHAIRMAN: Yes.

MR. SAGE: Yes.

THE CHAIRMAN: You don't determine the

policy do you Mr. Sage?

MR. SAGE: No sir, I don't.

THE CHAIRMAN: Or do you?

MR. WHEAT: Mr. Chairman he has already

THE CHAIRMAN: That is what I am getting



at.

MR. FULLERTON: Mr. Chairman, Mr. Sage - referring back to page 2, purchasing, are there any of these drugs bought by tender?

MR. SAGE: They are all bought by tender. Any large quantity. That doesn't apply to written tenders sir but we do negotiate for every large purchase with a number of manufacturers.

MR. FULLERTON: I take it from the second paragraph of Section III that all the manufacturers sit in on these meetings to discuss price. It doesn't refer to tenders.

MR. SAGE: Well it does somewhere here.

MR. RICE: Second last paragraph on page 2 I think refers to tenders there of large orders. Perhaps you would explain to the Committee what a large order is.

MR. SAGE: It's a supply that lasts us - that would last us three months would be a large order.

MR. RICE: What would that amount to in dollars?

MR. SAGE: Would depend on the type of drug.

MR. RICE: Well what is the policy when you are going to call for tender? Where do you draw the line for what is a large order that you are going to call tenders for?

MR. SAGE: We try and provide for a year ahead. If we can get supplies every three months - we



MR. TULLER: Now, Mr. Tuller, is it -

referring back to page 2, paragraph 2, and there -

of these things brought by tender?

MR. TULLER: They are all brought by tender.

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tenders are but we do negotiate for every large quantity

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MR. TULLER: I come to from the

second paragraph of Section III that all the material

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MR. TULLER: Well, it does refer to tender.

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the line for what is a large order that you are going

to call tenders for?

MR. TULLER: We try and provide for a year

ahead. If we can get supplies every three months - we



would take a whole year's supply into our pharmacy. I wouldn't have any idea of the number of dollars involved in a stated order. It would be a lengthy supply for one drug.

MR. RICE: Of your drug account what percent of these large orders would be your total drug account?

MR. SAGE: I wouldn't have that information sir. My chief pharmacist might, if I am permitted to ask him.

THE CHAIRMAN: Who is the chief pharmacist of your hospital Mr. Sage?

MR. SAGE: Mr. McCray.

MR. RICE: Mr. McCray is here this afternoon. When you place these orders for the purchasing where do you purchase from, manufacturers or wholesalers? Where do you place your order?

MR. SAGE: In most cases directly from the manufacturer. Some purchases from the distributor.

MR. RICE: Can you tell us what percent of your orders are placed with manufacturers and what percent are obtained from distributors?

MR. SAGE: I might guess. I would say 90%.

MR. RICE: 90% from the manufacturers?

MR. SAGE: Yes, the manufacturers.

MR. RICE: And when you place these orders with the manufacturers, particularly the large orders, do you get quantity discounts?

MR. SAGE: Yes. That is the idea of

would take a whole year's supply into our pharmacy.

I wouldn't have any idea of the number of dollars involved in a stated order. It would be a lengthy supply for one drug.

MR. RICE: Of your drug account when

percent of these large orders would be your total

total supply?

MR. SAGE: I wouldn't have that information.

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THE CHAIRMAN: Who is the chief pharmacist?

chief of your hospital Mr. Sage?

MR. SAGE: Yes, sir.

MR. RICE: Mr. McGraw is here this

afternoon. When you place these orders for the purchase

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MR. SAGE: Yes, the manufacturers.

MR. RICE: And when you place these orders

do you get quantity discounts?

MR. SAGE: Yes, that is the idea of



making ---

MR. RICE: Could you give us any idea as to what these discounts would amount to?

MR. SAGE: The percentage below list price?

MR. RICE: Yes, below list price; what you would normally pay for them if you weren't buying them by tender and getting this large quantity discount.

MR. SAGE: 10 to 20% difference. I think the discount off list for retail, as you know it, probably 50 to 60% before we finish.

MR. RICE: What is the normal?

MR. SAGE: Normal is 40.

MR. RICE: You buy 40% off list price?

MR. SAGE: Yes.

MR. RICE: And then from these tenders it may be 50 to 60%.

THE CHAIRMAN: I think you should pursue that in detail Mr. Rice. We want the information as to what the facts are. Pick a drug, pick a specific account and give us the information.

MR. RICE: Could you give us some examples of a drug that you purchase on these quantity discounts, purchased by tender?

MR. SAGE: I can't, but I have a man here who might. Do you want specific drugs?

MR. RICE: Could Mr. McCray come forward Mr. Chairman. He is the chief pharmacist on the staff of the hospital.



Q. Now, would you give us any idea

as to what the discount would be on these

items, please, before that

100-101

Q. Now, would you give us any idea

you would normally pay for these items, you wouldn't buying
them by tender and get a discount, is that right? I think
MR. SAGG: Yes, that's the difference, I think

the discount off that for retail, as you know it,

probably 50 to 60% before we finish.

MR. RICE: What is the normal?

MR. SAGG: Normal is 40%.

MR. RICE: You say 40% off that price?

MR. SAGG: Yes.

MR. RICE: And then these tenders

it may be 50 to 60%.

THE CHAIRMAN: I think you should purchase

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examples of a drug that you purchase on these quantity

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MR. SAGG: I can't, but I have a man

here who might. Do you want specific drugs?

MR. RICE: Yes, I would like to know

Mr. Chairman. He is the chief pharmacist on the staff

at the hospital.



THE CHAIRMAN: You can produce the evidence at an appropriate time. I think we want a little more detail than I think we are getting, 50 or 60% discount. We want the specifics.

MR. SAGE: We will produce that Mr. Chairman any time you like to have us back.

MR. RICE: Do you purchase them once a month or just as your inventory goes low?

MR. SAGE: That depends on the inventory controller and what it looks like. We look well ahead and deliveries may not be fast for an urgency, so might be a month. Three months before we actually come to the point of needing them. Might be a delay on large quantity.

MR. RICE: I notice in your analysis that you have no method for analysing the drugs you purchase. Is there any way or is there any control of these drugs to find out whether your drugs are potent other than trial and error?

MR. SAGE: Only the guarantee from the supplier, from the manufacturer where he does test in accordance with the Food and Drug Act and the extent to which he does test them we enquire into. We have some written guarantees that they do test them. Some of these are lengthy. Some are not so lengthy, from the drug houses.

THE CHAIRMAN: What is the nature of them?

MR. SAGE: That they test every product



THE CHAIRMAN: You can produce the evi-

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MR. SAGE: We will produce that now.

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THE CHAIRMAN: What is the nature of

Chemical

MR. SAGE: That they test every product



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they produce, spot check every batch of products that come off their supply lines; that they test for purity and test for anything that there might be ---

THE CHAIRMAN: Mr. Sage, that is a representation that they are going to do something to something they sell to some hospital. What is the representation? What do they do? Do they do anything or do they just tell you they are going to do something? I take it you are getting assistance from your advisors?

MR. SAGE: I am just getting a copy of a letter sir from a supplier.

THE CHAIRMAN: Look Mr. Sage this is not directed - our enquiry has to do with the protection of the public interest.

MR. SAGE: Yes sir.

THE CHAIRMAN: That is the only reason we are here. It has nothing to do with you as an individual; with your hospital as a hospital or with any other person or institution at all. We are just concerned with the public interest.

MR. SAGE: That is right. I understand that sir. This is a copy of a letter from one supplier.

Charles E. Frosst & Co.
P.O. Box 247, Montreal 3, Canada.

June 8, 1961.

Dear Mr. McCray,

Mr. Johnston of our Toronto Office has relayed to me your inquiry regarding our standardization procedures.



they produce, spot check every day or products that
come off their supply lines, that they test for purity
and test for anything that there might be --

THE CHAIRMAN: Mr. Stagg, what is it?

representation that they are going to do something to

something they said to some extent -- what is the

representation? What do they say to each other, that

or do they just tell you they are going to do something?

I take it you are getting assistance from the industry?

MR. STAGG: I am just going to say that

letter is from a supplier.

THE CHAIRMAN: Look Mr. Stagg, this is not

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MR. STAGG: Yes, sir.

THE CHAIRMAN: That is the only reason for

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with the public interest.

MR. STAGG: That is right. I understand

that sir. This is a copy of a letter from one supplier.

Charles E. Brown & Co.
P.O. Box 247, Montreal 3, Canada.

June 3, 1961.

Dear Mr. McGraw,

Mr. Johnston of our Toronto Office has

replied to me your inquiry regarding our sterilization



For your information, every product we manufacture either meets or exceeds the requirements laid down by the Food and Drug Act. We maintain a complete control department whose duties, generally, are as follows:

1. They analyse all material which we use in formulating our products to ensure that they are up to the strictest standards.
2. Our control measures ensure that every ingredient and every step in manufacture is checked and cross-checked by several people, to minimize any chance of error.
3. The finished product is carefully analysed to make sure that it meets the standards required by the Food and Drug Act or higher.
4. A specimen of every batch of every product we manufacture is retained in our plant. This sample is examined and analysed, if necessary, from time to time to make sure that its potency, stability, taste, colour, etc. are being maintained. Should we find that at any time any batch of our product does not last what should be regarded as the normal life span of such a product, we recall from the trade all of that batch and replace



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Should we find that at any time any

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the trade all of that batch and replace



it, no charge.

We set the highest possible standards for the quality of our products. We take every possible step to see that these standards are achieved and maintained. We protect our customers by unequivocally guaranteeing the quality of any product we sell.

I hope this information will be sufficient for your requirements. If you do require further information, in future, we would be pleased to give it to you provided we have more time for preparation.

Signed. G.W. Holden, PhD.
Assistant Director Research

P.S. I am enclosing for your information a copy of a brochure which we produced a few months ago. This outlines some of the many control procedures we use and also lists the personnel who work in our Research and Control Laboratories.

MR. RICE: Could you tell us the name of that supplier?

MR. SAGE: This is the Charles E. Frosst Company.

MR. RICE: Is there any check made by the hospital or anyone on behalf of the hospital that they are carrying out that guarantee?

MR. SAGE: Well we don't have anyone that is qualified to really find that out Mr. Chairman. We would have to have a Ph.D chemist I would think in



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MR. SAGE: Well we don't have anyone

that is qualified to really find that out Mr. Chairman.

We would have to have a Ph.D. chemist I would think in



our employ to determine whether they are carrying out proper testing or not. We don't employ one. We have found the best guarantee is the reputation of a company, an organization is sufficient. We have never had any reason to doubt that; not in my experience at least.

THE CHAIRMAN: What date is that letter there?

MR. SAGE: That is just a few days ago Mr. Chairman, June 8th, 1961.

MR. RICE: Is there any way of checking on this type of letter from various manufacturers to know which manufacturer you are going to accept a guarantee from on letters like that and which you are not going to accept their guarantee by letter?

MR. SAGE: No, I don't believe there are at the present time any procedures taken by our hospital to assure us of that; only by experience and knowledge. Knowledge and experience.

MR. RICE: Can any manufacturer write you a letter along those lines and then be considered a manufacturer of good drugs?

MR. SAGE: I am sorry, I missed that.

MR. RICE: Could any manufacturer send you a letter along those lines and then would he be considered a proper manufacturer to purchase drugs from without any further analysis or check?

MR. SAGE: With other factors. Depending on what our medical doctors report, I suppose, as to



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the satisfaction of the drug as it is used. All those things would enter into it. I was concerned primarily with the fact that we are inclined to take the verbal assurance of the detail men that their company do these things so I asked for a few things in writing.

THE CHAIRMAN: When did you ask for that in writing?

MR. SAGE: Heretofore we have presumed what they tell us is the truth. We have no indication it has not been.

THE CHAIRMAN: Mr. Sage this is a rather interesting point because it has to do with the validity and the worth of what you believe in because what you believe in has to do with the public. You see it just happens that you are on the same side of the fence representing the public's interest as this Committee. How do you know that letter from the Charles E. Frosst Company is worth anything? It just happens that - I might tell you that if I were in your place I would accept the worth of that letter from the Charles E. Frosst Company because I think they are a reputable company. How do you know that that letter is worth five cents?

MR. SAGE: I don't know personally but I would think that some of the medical men around our Pharmacy Board would know something about the companies we deal with.

THE CHAIRMAN: So you are depending on them are you?



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Frost Company because I think they are a reputable

company. How do you know that that letter is worth

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MR. SAGE: I don't know personally but

I would think that some of the medical men around our

Pharmacy Board would know something about the companies

we deal with.

THE CHAIRMAN: So you are depending on

them are you?



MR. SAGE: Yes, we do sir heavily on our Pharmacy Committee.

THE CHAIRMAN: What I am getting at is this: I think it goes a little bit beyond that.

MR. SAGE: Maybe.

THE CHAIRMAN: This is no reference, and I want this clearly understood, no reference to this particular company at all. How can you, as a purchasing man, accept a letter of one or one-and-a-half pages from a so-called manufacturing company as representing anything? How do you?

MR. SAGE: I am sorry, I didn't hear the last part of your question.

THE CHAIRMAN: How do you?

MR. SAGE: Before that.

THE CHAIRMAN: How do you accept a letter as representing any worth?

MR. SAGE: Well because they are a reputable company.

THE CHAIRMAN: You think they are reputable you mean.

MR. SAGE: We know from experience and we have never had any bad experience with them. How do you measure reputation of any company?

THE CHAIRMAN: I am wondering if your duty and our duty doesn't go beyond that.

MR. SAGE: It just might. It just might Mr. Chairman.

THE CHAIRMAN: It just what?



MR. SAGE: Yes, we do sit heavily on

our shoulders.

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this: I think it goes a little bit beyond that.

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THE CHAIRMAN: It just might.



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MR. SAGE: It just might, I say, go beyond that.

THE CHAIRMAN: I think it does.

MR. SAGE: It is going to cost money to find out, I respectfully submit.

THE CHAIRMAN: How much is it going to cost to find out?



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THE CHAIRMAN: How much is it going to cost to find out?

MR. SAGE: The analytical department in a hospital, we face up to a payroll of \$15,000.00 a year.

THE CHAIRMAN: Did you ever get a credit report on any of these companies?

MR. SAGE: We don't need to get a credit report, we have dealt with most of them for years and years.

THE CHAIRMAN: What evidence have you in your files on their financial stability?

MR. SAGE: We have none. Why would be interested in their financial stability. We are primarily interested in their reputation as a pharmaceutical office.

MR. BRYDEN: Does that letter you produced help you at all in that? As I understand it, the letter is meaningless unless the company has a good reputation, and if it has a good reputation the letter superfluous?

MR. SAGE: That is right.

THE CHAIRMAN: Reputation is not superfluous. You could have a good-looking girl.

MR. BRYDEN: A company not in your past experience, how would it establish a reputation with you?

MR. SAGE: It would have to submit some of its products, and the pharmaceutical committee would look at it and we could put some of the products through our own lab and test them for impurities.

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MR. BRYDEN: You don't normally do that?

MR. SAGE: No.

MR. BRYDEN: Isn't there a danger that in your purchasing policy you will inevitably be confined to a few well-established firms, which may not be offering the best prices?

MR. SAGE: That could well be, because we don't stray far away from the reputable companies.

MR. BRYDEN: Let us make a differentiation between reputable and well-known. A person could have a good reputation without being well-known. Isn't it possible that you could be confined to the well-known companies because they are reputable to you?

MR. SAGE: I think that is correct.

MR. BRYDEN: Would it help if the Hospital Association or the Provincial Government, or some other body, provided an inspection service to inspect plants. You say it is too costly for you to do it yourself. If that was done on a central basis, would it help you perhaps to broaden your range of purchase?

MR. SAGE: Yes, we could send a letter of this type for example and have it checked by an expert, if they employed one, and they would certainly make it sit a little bit more comfortable.

MR. BRYDEN: I was a little surprised when you told the Committee that most of your purchases were by brand names. In view of your declared policy of not necessarily buying brand names.

MR. SAGE: It is to substitute wherever we



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find it is the same product, but it might still be under a brand name, in fact in most cases it would be.

MR. BRYDEN: I can see that part of your policy would not be just to have a duplication of products under several names, you would just have one if there were several in the field?

MR. SAGE: Yes.

MR. BRYDEN: I have an article of the Journal of the American Medical Association for September 1960 with regard to the New York Hospital Formulary, and they state that all their purchasing is done under non-proprietary names. That does not mean to say that they do not have brand names, but they purchase everything under the non-proprietary names, and whoever gives them the best deal, they buy from, and the listing is always under the non-proprietary name.

MR. SAGE: It might be worth a try.

MR. BRYDEN: Do you know how many items you have listed in the formulary in your hospital?

MR. SAGE: Approximately 3,000.

MR. BRYDEN: I may say that the item I am quoting from is an editorial appearing in the Journal of the American Medical Association for the date I gave. Here is a couple of sentences:

The edition of The New York Hospital Formulary just published contains 359 different drugs (not including reagents, solvents, etc., or mixtures or special preparations of drugs already enumerated).



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a brand name, in fact in most cases it would be.

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Journal of the American Medical Association for

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Formulary, and they state that all their prescribing

is done under non-proprietary names. That does not

mean to say that they do not have brand names, but

they use the generic name.

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from, and the listing is always under the non-

proprietary name.

MR. SAGE: It might be worth a try.

MR. BRYDEN: Do you know how many items

you have listed in the formulary in your hospital?

MR. SAGE: Approximately 1,000.

MR. BRYDEN: I can say that the item I

am quoting from is an editorial appearing in the

Journal of the American Medical Association for the

date I gave. Here is a couple of sentences:

The edition of The New York Hospital

Formulary lists the following: (not including reagents, solvents, etc., or mixtures

or special preparations of drugs already enumerated).



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The pharmacy of a hospital which does not have this form of control may stock 2,500 drugs in 10,000 different forms.

I am a layman, but what I get out of that is that they really reduce their inventory very greatly by the system they use.

MR. SAGE: That is possible, but I don't think that represents the total number of items that they have in their pharmacy.

MR. BRYDEN: No, it says it does not include reagents, solvents and mixtures.

THE CHAIRMAN: Will you develop that along the line of the right of substitution and that sort of thing with the witness?

MR. BRYDEN: I am not quite certain what you mean Mr. Chairman, but I will ask a couple of questions. I would like again to refer to the last paragraph in your brief, from which I take it there is a definite desire on the part of your pharmacy committee to reduce inventory to avoid unnecessary duplication?

MR. SAGE: That is right.

MR. BRYDEN: I am wondering if it couldn't be carried further by developing some system of, if necessary, inspecting manufacturing facilities so you would have a wider range of choice in your selections. In other words, you don't have to rely on this intangible reputation. You could have someone go and see for you that they are actually manufacturing properly under proper control?



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Sage

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MR. SAGE: It could be done, but I don't see why any individual hospital would want to do it, but I can see it as a possible job for the Ontario Hospital Association for example.

MR. BRYDEN: You think it would be too expensive for even a hospital of your size?

MR. SAGE: It would seem to be fairly expensive. Besides your payroll you would have a whole lab to build, and you would have constant overhead in the whole department of about \$20,000.00 or \$25,000.00, and whether we would save that I am not sure we might.

MR. BRYDEN: You may not have to have a test lab if you at least inspected the manufacturing premises to satisfy yourself that quality control was adequate in those premises?

MR. SAGE: Who is going to say that? I am not a chemist. I would have to hire a chemist to do that.

MR. BRYDEN: Are not there qualified men around who could be hired for the specific service and not on a full-time basis?

MR. SAGE: On a fee for service basis, possibly. I don't know. It might be worth a try.

MR. BRYDEN: They also say in the same journal with respect to the policy of listing drugs only under the non-proprietary names, and purchasing only in that method. The question is asked:

Does this rule risk the use of inferior drugs in The New York Hospital? The Hospital insists



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on U.S.P. and N.F. standards. The Formulary Committee nevertheless recognizes the importance of purchasing drugs manufactured only by houses whose reputations are impeccable. It inspects the plants it does not already know well. But it does not confuse trademarks or proprietary names with conscientiousness. The Hospital has never had any difficulty which could be attributed to the purchase of inferior drugs through the old American system of open competition.

Again I put that forward to you?

MR. SAGE: I agree with all that. In fact I raised the same questions at our place when examining this brief, how far we went to satisfy ourselves what reputation, if you like, and the extent to which these people are tested. The next step obviously is to go out and inspect their premises, and we would have to hire an expert to do that.

THE CHAIRMAN: I think, Mr. Sage, you should understand that this Committee, at least I will speak for myself. We are very sympathetic to what your hospital is doing. We are very interested in the research work that you are doing with respect to children's diseases, and the efforts you are making to tackle the problem. We are also interested in the emotional appeal that arises therefrom with respect to the public interest in what you are doing. Two sides to the razor's edge, do you understand that?

MR. SAGE: Yes sir.

THE CHAIRMAN: What would your total purchases



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MR. SAGE: Yes sir.

THE CHAIRMAN: What would your total purchases



In a year be at the Hospital for Sick Children?

MR. SAGE: Total purchases?

THE CHAIRMAN: The whole purchasing budget, leaving salaries out of it. The purchasing of supplies. What would that figure be?

MR. SAGE: Approximately \$2,000,000.00. Our total budget is around \$6,000,000.00.

THE CHAIRMAN: Would you like to elaborate on that \$6,000,000.00 and give us the categories of it? \$2,000,000.00 for medical supplies, drug supplies?

MR. SAGE: \$2,000,000.00 for all supplies, and approximately \$4,000,000.00 for payroll.

THE CHAIRMAN: \$4,000,000.00 payroll, and \$2,000,000.00 drug bill?

MR. SAGE: Not drugs, all supplies.

THE CHAIRMAN: Of the \$2,000,000.00, what is the figure for the area of prescription drugs that we are concerned with in this enquiry?

MR. SAGE: Well, sir, not very much. It is \$274,000.00 in 1960.

THE CHAIRMAN: Would you agree, Mr. Sage, that that item we are talking about is a rather crucial item, or an important one, with respect to these young people?

MR. SAGE: I think it is indeed important, because it continues to rise as you can observe from page 8.

THE CHAIRMAN: But you don't have any testing facilities in your hospital for this?

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THE CHAIRMAN: Would you like to increase

on that \$6,000,000 and give us the salaries of the

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MR. SAGGE: \$2,000,000 for all supplies.

and approximately \$1,000,000 for payroll.

THE CHAIRMAN: \$3,000,000 for payroll, and

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THE CHAIRMAN: But you don't have any

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MR. SAGE: Not for quality, no.

MR. RICE: These letters of guarantee or representation that you get from the manufacturers. Do you get them from every manufacturer you get drugs from?

MR. SAGE: I assure you we will.

THE CHAIRMAN: Have you?

MR. SAGE: We have off and on.

THE CHAIRMAN: Why did you get that letter you have now?

MR. SAGE: Because I was asking the same questions as today. We were taking the words of a detail man that his company was a good company, plus the fact that we had been dealing with them for quite a few years.

THE CHAIRMAN: But even today you don't know if that letter is worth the paper it is written on, do you?

MR. SAGE: I don't from first-hand knowledge, but --

MR. RICE: This is a new policy of the hospital, requiring these letters?

MR. SAGE: That is right.

MR. PRICE: This just backs up, does it, what the detail man had told you before. In other words, you were not satisfied in coming before this Committee with his word. You wanted something more?

MR. SAGE: That is correct. You wanted



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MR. SAGE: That is correct.

MR. WHITNEY: Have you made any purchases from drug companies such as the name of Empire or Dominion, or Gilbert? Have they submitted prices or tenders?

THE CHAIRMAN: Solicited business?

MR. SAGE: The only name that I have any reaction on there is Gilbert, because his name has been in the paper a couple of times. We buy hospital supplies from him, but no amount of drugs of any consequence.

MR. WHITNEY: You haven't heard of the names of Empire or Dominion Drug Companies?

MR. SAGE: No, they are pharmacy suppliers and we do not deal with them.

MR. RICE: Is there any wastage in drugs over the year?

MR. SAGE: A few years ago there was an agreement that we put a date stamp on all of our drugs, and when in our opinion, or their opinion, they come to a point of obsolescence or deterioration, we return them for credit.

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MR. RICE: And you get full credit on return?

MR. SAGE: Yes, on the basis of the type of drugs.

THE CHAIRMAN: Do you put a date on the bottle, on the package?

MR. SAGE: On the package, yes.

MR. RICE: Can you return opened packages?

MR. SAGE: Not likely. I am not sure.

MR. RICE: When you dispense a pre-packaged drug to the patient do you remove the manufacturer's label?

MR. SAGE: In most cases we may remove the manufacturer's label and substitute our own.

MR. RICE: Can you inform the Committee the reason for that?

MR. SAGE: It is usually a prescription from a doctor and the doctor is the one whose name is on the prescription. That is the only reason.

MR. RICE: Couldn't you put the doctor's name on the manufacturer's label somewhere?

MR. SAGE: The manufacturers might object.

MR. RICE: When a prescription comes into the dispensary is it the chief pharmacist who fills all these prescriptions or are there some non-pharmacists also fill prescriptions?

MR. SAGE: They are all pharmacists. Three of them, including the chief, are registered in



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Three of them, including the chief, are registered in



Ontario; the others are registered in England, Australia, New Zealand. They can't get registration here.

THE CHAIRMAN: Why can't they get registration?

MR. SAGE: They have to take a year's tuition and pass the examination.

MR. PRICE: Your hospital considers them qualified without that year's tuition?

MR. SAGE: Yes, if they get a certificate from their own pharmacy association.

THE CHAIRMAN: Where do they come from?

MR. SAGE: Well, Australia and England chiefly.

THE CHAIRMAN: But they can't qualify in Ontario.

MR. SAGE: They can qualify if they go to school.

THE CHAIRMAN: Don't make snide remarks. They can't qualify. Mr. Sage, they can't qualify or else they would get their certificates. Isn't that the answer?

MR. SAGE: In some countries there is an arrangement whereby you can --

THE CHAIRMAN: Oh, now you are talking about the qualification requirements. I am saying that the fact is that they can't qualify in Ontario. Whether it is wrong doesn't matter, but they can't qualify in Ontario.



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MR. SAGE: If you want to use the word "qualify" it is all right with me.

THE CHAIRMAN: The fact is if they don't qualify they don't get the certificate.

MR. SAGE: They have to prove --

THE CHAIRMAN: The fact is that under the Ontario regulations, right or wrong, they can't qualify. Is that right or wrong?

MR. SAGE: That is right.

THE CHAIRMAN: Of course it is right. Now, it is another question whether it is a legitimate right or wrong.

MR. PRICE: I take it your hospital authorities consider the requirements of the specific authorities in this Province of Ontario restrictive in these cases.

MR. SAGE: I wouldn't be recorded as saying that.

MR. PRICE: I take it your hospital authorities consider they are qualified to dispense prescriptions.

MR. SAGE: Under supervision. They are never left alone.

THE CHAIRMAN: Let me put it another way. You employ, under supervision, people to dispense prescriptions who can't qualify under our existing law.

MR. SAGE: We have registered pharmacists there all the time.

THE CHAIRMAN: 24 hours a day?



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MR. SAGE: We are not open 24 hours a day.

THE CHAIRMAN: Does the hospital close down part of the day?

MR. SAGE: No. I have explained that at some length. We have arrangements made to take care of the evening hours, under the direction of doctors.

THE CHAIRMAN: What we are trying to get at - this is no reflection on you or your chairman of your Board or anyone else - all we are trying to get at - and if your assistant there would turn around and listen to us. Are you interested in what we are talking about or not?

MR. McCRAY: Very much, sir.

THE CHAIRMAN: We are not concerned with the validity or otherwise of the requirements of the Pharmacy Act, but we are interested in some of the problems which may arise out of this enquiry. We are not trying to criticise the Hospital for Sick Children or its administration, but we are interested in trying to get to the problems you are faced with with a view to helping you, and that is why we are here, that is why we are spending all this time here. Do you see any suggestions out of all of this problem of dispensing and the supervision of the dispensing of so-called prescription drugs that would be helpful to the public, Mr. Sage?

MR. SAGE: No, I think that --



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MR. SAGE: No, I think that --



THE CHAIRMAN: You think the system as it is now is all right or in need of correction?

MR. SAGE: I think it should be supervised. I think there should be a central testing agency for hospitals, I agree, wholeheartedly. I think it is taken too much for granted. In our case we have never had any problem arise.

THE CHAIRMAN: Is the present system good enough? Does it meet the needs of the public?

MR. SAGE: It meets the needs of our patients; so far it has. That is all I can say to that.

THE CHAIRMAN: You are an experienced operator. Is the present system okay or does it need amending?

MR. SAGE: It can do with amendments.

THE CHAIRMAN: In what respect?

MR. SAGE: Following through on the testing of drugs. That would be the only loophole that I could see in our case. I think otherwise we have it pretty well controlled.

MR. PRICE: Would you tell me, Mr. Sage, to what extent your manufacturing is influenced by price as opposed to quality?

MR. SAGE: I would say very little. That comes out after they have piled up the samples in front of them and analysing the various types of drugs. That is up to the purchasing agent to determine whether we have bought the same product or a



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mine whether we have bought the same product or a



better one at a similar cost.

MR. PRICE: Would you say that your policy is one of quality first?

MR. SAGE: Yes, sir.

MR. BOYER: Mr. Sage, on page 5 of your brief you speak of out-patient prescriptions, 130 clinic prescriptions are dealt with through the out-patients' wicket each day. Are those prescriptions sold at cost?

MR. SAGE: Cost plus 10%.

MR. BOYER: I was rather puzzled comparing your statement with a statement made by Mr. Keating, who is a pharmacist, at page 1830 of our record. There Mr. Keating says: "A hospital is not allowed to dispense a prescription and charge for it". Was that a correct statement or not?

MR. SAGE: That is not a correct statement as far as we are concerned. We charge all the time, patients, out-patients, employees, and so on.

MR. BOYER: That is quite within the hospital's rights?

MR. SAGE: Yes.

MR. BOYER: Of course, he referred to the hospital selling prescription drugs to an employee, but I was concerned more about out-patients. The hospital may dispense a prescription to an out-patient at cost plus 10% or anything that you may care to charge.

MR. SAGE: That is correct.



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MR. SAGG: That is not a correct state-

ment as far as we are concerned. We charge all the
time, patients, out-patients, employees, and so on.
MR. BOYER: That is quite within the

hospital's rights?

MR. SAGG: Yes.

MR. BOYER: Of course, he referred to
the hospital selling prescription drugs to an employee,
but I was concerned more about out-patients. The
hospital may dispense a prescription to an out-patient
at cost plus 10% or anything that you may care to
charge.

MR. SAGG: That is correct.



MR. WREN: Do you apply a sales tax?

MR. SAGE: No. If we don't charge 10% over cost we don't have to pay manufacturer's sales tax, but we will have to pay this 3% sales tax coming up in September, I understand.

MR. WREN: How does a person qualify as an out-patient to be entitled to this rate of purchase?

MR. SAGE: There are two types of out-patient, private out-patient and clinic. The clinic out-patients have to have a screening test. If they earn below a certain figure they get doctors free and x-rays free and drugs not more than two dollars, and so forth. The private out-patients can be brought in and seen by a doctor in our hospital with a prescription and he will fill it on that occasion. We will not continue to fill it if the patient is just walking in the door; they have to see a doctor.

MR. WREN: When you refer to employees, does that refer to just adult employees or their children as well?

MR. SAGE: No, it is supposed to be adult employees. We don't go into the family too closely unless there is an obvious abuse, and so on.

MR. WREN: If a child of an employee is ill, would that prescription be entitled to be filled at cost?

MR. SAGE: It depends on the level of the employee. I may look into it and might not like it. It is really a fringe benefit for employees.



MR. WATKINS: Do you require a salary?

MR. SAGOR: No, it is a salary charge for

over cost we don't have to pay. The salary is a salary
tax, but we will have to pay this 35 percent tax every
up in September, I understand.

MR. WATKINS: How does a person qualify for

an out-patient to be entitled to that kind of treatment?

MR. SAGOR: There are two types of out-

patient, private out-patient and clinic. The private

out-patient has to have a referring doctor. In the

clinic below a certain figure they get treatment from the

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It is really a fringe benefit for employees.



MR. WREN: For a child what level or yardstick of income is used?

MR. SAGE: \$55 a week with one child, rising to \$70 a week with four children or more.

MR. TROTTER: When you tender for drugs do you find that the tenders are much the same, or is there very much difference in the price range in the tenders?

MR. SAGE: I am sorry, I am not close enough to answer that one.

MR. McCRAY: There are substantial differences.

THE CHAIRMAN: Mr. McCray is now putting this in the record. Mr. McCray is the assistant to Mr. Sage in answer to the question. Now, the answer Mr. McCray gave was what?

MR. McCRAY: The differences could be from 10%, 20% and occasionally more.

MR. SAGE: 10%, 20%, occasionally more.

MR. TROTTER: Do you find that the companies, the manufacturing drug companies have very many detail men call on you?

MR. SAGE: Yes.

MR. TROTTER: About what would their calls average per week?

MR. SAGE: I would say an official session twice a week with our pharmacists and purchasing agent, twice a week. Probably three or more every morning.



MR. WATSON: How a little more, I would

percentage of income is used

MR. SAGE: \$75 a week with one child,

rising to \$100 a week with two children or more.

MR. TROTTER: When you refer to one,

do you find that the tenders are about the same, or is

there very much difference in the price range in the

tenders?

MR. SAGE: I am sorry, I am not close

enough to answer that one.

MR. MCGEE: There are considerable differ-

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MR. SAGE: 10%, 20%, occasionally more.

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the manufacturing drug companies have very many sales

men call on you?

MR. SAGE: Yes.

MR. TROTTER: About what would that

calls average per week?

MR. SAGE: I would say an official session

twice a week with our pharmacists and purchasing agent,

and then a number of other calls.



H/PB/hm

MR. TROTTER: When you have the meetings with these men, are there all the different companies at the same time or do you talk to them at different times?

MR. SAGE: We talk to them at different times on appointment, fifteen to twenty minutes apart. They wait in the outer-office.

MR. TROTTER: Would you do the buying?

MR. SAGE: No, I don't. Mr. McCray, our chief, Mr. H. F. Morgan, our purchasing agent and Mr. Sneddon our assistant director.

MR. TROTTER: I was wondering if possibly Mr. McCray could possibly add to the answer.

THE CHAIRMAN: I presume Mr. McCray is going to giving testimony in a few moments.

MR. WREN: Returning to the Out-Patient problem. ...

THE CHAIRMAN: Before you return, I don't follow the line of questioning you are directing because I would think in any well-run hospital or business organization they would be perfectly willing and receptive to receive any detail man who had an idea to offer them.

MR. TROTTER: Mr. Chairman....

THE CHAIRMAN: You are suggesting that they take too much time.

MR. TROTTER: I was wondering how much pressure you were subject to from the detail men or



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the drug companies. That is a question quite consistent with many directed in the same line to various witnesses.

THE CHAIRMAN: Is there any pressure -- put that question to him. Is there any pressure, undue pressure put on the hospital and are they incompetent or unable to receive the pressure, that is the question.

MR. TROTTER: I would first ask, are you subject to a great deal of pressure from the detail men and drug companies.

MR. SAGE: The word pressure would have to be refined. We know we are going to have detail men and we welcome them in many, many instances. Some may be interested in sales, generally speaking they are very considerate. We try to arrange two days a week to listen to their submissions.

MR. TROTTER: I noticed, Mr. Chairman, that Mr. McCray is not on the list of witnesses today, that is why I didn't expect Mr. McCray to be heard.

THE CHAIRMAN: I think we should develop this as we require.

MR. TROTTER: Do you get a great deal in the way of magazines and pamphlets from the drug companies?

MR. SAGE: I don't, Mr. Chairman. I must again refer you to the Chief Pharmacist. I am not close enough to that aspect of a pharmacy operations.

THE CHAIRMAN: Do you have anything to do,



Mr. Sage, with the purchasing of so-called prescription drugs?

MR. SAGE: No, sir.

THE CHAIRMAN: Well, there you are, the witness is not competent to answer the questions you are directing.

MR. RICE: Could you tell us, these employees, private outlay -- are doctors included in that they obtain drugs from the dispensary -- that is for themselves?

MR. SAGE: They are not supposed to. They don't use them for themselves specifically.

MR. RICE: Could they obtain them for their office needs?

MR. SAGE: No.

THE CHAIRMAN: You mean for their own use?

MR. RICE: For their office use or their own use. I was wondering if they could get them for their office use. He said no. Have you ever had any complaints about drugs at all, quality or the

MR. SAGE: Not very often. Once in a while a doctor will say he didn't get results from such and such a drug. He firmly believes in such and such another drug. It is a matter of opinion in many cases.

MR. RICE: Would that be a case of the substitution of the hospital?

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THE CHAIRMAN: Who is "we"?



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MR. SAGE: The Chief Pharmacist and the Pharmacy Committee check very carefully with the doctors on the Pharmacy Committee. There is not chance of any mistake. You could get in a lot of trouble with that.

MR. RICE: I notice on the question of substitution, Regulation 15, "Where a drug is ordered by its trade name i.e., Meticorten, a pharmacy has the option of substituting a cheaper drug of an identical chemical constitution". First of all is the doctor who orders that -- the Pharmacy is the Chief Pharmacist?

MR. SAGE: That is correct.

MR. RICE: Is that substitution within the formulary of the hospital?

MR. SAGE: It would be. He would have to -- that is where the substitution is.

MR. RICE: The doctor is obliged to prescribe the drug in the hospital formulary to begin with and the Chief Pharmacist can substitute?

MR. SAGE: He can order anything we have got, anything he likes.

MR. RICE: The doctor can prescribe any drugs he wants, whether in the hospital formulary or not, and then the Chief Pharmacist has the right under this regulation to substitute another drug for that?

MR. SAGE: That is correct.

MR. BRYDEN: On prescriptions?

MR. SAGE: I beg your pardon?

MR. BRYDEN: Your hospital stocks Brand A and the doctor stated in his prescription it would be

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Brand B, and that wasn't in stock, the pharmacist can put Brand A in substitution for Brand B?

MR. SAGE: That is right.

MR. RICE: Is that without consulting the doctor who prescribed the drug?

MR. SAGE: No, probably he would talk to him and explain it is our policy.

MR. BRYDEN: What if the doctor, if he insisted?

MR. SAGE: He would probably be sent to the Chief of the Pharmacy Committee and he might say, go ahead and fill it in this instance, this fellow is insisting, fill it. Generally speaking it doesn't apply. They are most co-operative.

THE CHAIRMAN: I think it is only fair to remind you, Mr. Sage, this right of substitution is a highly dangerous subject. If you are suggesting there is a right of substitution on the part of the Chief Pharmacist.....

MR. SAGE: It has qualifications in it.

THE CHAIRMAN: Of course, I would hope it does because if it doesn't I am going to go out and speak to the Prime Minister this afternoon, if there is no limitation on it.

MR. SAGE: It has to be exactly the same.

THE CHAIRMAN: The right of substitution cannot exist, Mr. Sage, without the doctor's authority, is that not right?

MR. SAGE: The individual doctor's authority?



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THE CHAIRMAN: Yes.

MR. SAGE: I don't know that one.

THE CHAIRMAN: You don't know that one?

MR. SAGE: No.

THE CHAIRMAN: Okay. I think it is a highly dangerous situation.

MR. WREN: It is covered by rule 11 on page 10?

MR. SAGE: That is right.

MR. WREN: "The senior resident on the ward where the order is prescribed may call the prescribing doctor when necessary in order that a substitution may be made".

MR. SAGE: That is right.

MR. WREN: You have to call the prescribing doctor before you make a change?

MR. SAGE: In that case -- in fact, we always do, as a matter of practise.

THE CHAIRMAN: Do you? The way you are talking it sounds as if you don't.

MR. SAGE: No, we would always call him.

THE CHAIRMAN: You would always call him?

MR. SAGE: We have a public relations problem there as well.

THE CHAIRMAN: Public relations, is a matter of duty to the public.

MR. WREN: If I may, on this Out-Patient matter, again on page 5, you say that 130 clinic prescriptions are dealt with through the Out-Patient



THE CHAIRMAN: Yes.

MR. SAGE: I don't know that one.

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MR. WREN: Full time?

MR. SAGE: Yes.

MR. WREN: 30 or 35 on an average each each day?

MR. SAGE: Yes, up to one o'clock, that is when our clinics are open.

MR. WREN: When you issue a prescription to an out-patient is any fee charged in the cost for the pharmacist's service?

MR. SAGE: No sir.

MR. WREN: That is not part of the cost of the prescription?

MR. SAGE: No sir.

MR. RICE: Mr. Sage, I note in your brief on page 5, you refer to after hours, and then the night supervisor together with a responsible member of the staff obtain drugs. What type of person is a responsible member of the staff?

MR. SAGE: Generally a resident, which is a senior intern or associate resident which is number two man in the service. We have residents in all four clinical services, medicine, surgery, opthamology and ear, nose and throat. The senior man on duty has to accompany the supervisor to the pharmacy.

MR. RICE: Do they have the right of



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MR. RICE: Mr. Sage, I note in your brief on page 5, you refer to after hours, and then the night supervisor together with a responsible member of the staff obtain drugs. What type of person is a responsible member of the staff?

MR. SAGE: Generally a resident, which is a senior intern or associate resident which is number two man in the service. We have residents in all four clinical services, medicine, surgery, opthamology and ear, nose and throat. The senior man on duty has to accompany the supervisor to the pharmacy.

MR. RICE: Do they have the right of



wicket each day. How many pharmacists does it require

to fill these 130 prescriptions?

MR. SAGE: It keeps about four of them

pretty busy when the clinic is open.

MR. WRINN: Full time?

MR. SAGE: Yes.

MR. WRINN: 30 or 35 on an average each

MR. SAGE: Yes, up to one o'clock, that

is when our clinics are open.

MR. WRINN: When you issue a prescription

to an out-patient is any fee charged in the cost for

the pharmacist's service?

MR. SAGE: No sir.

MR. WRINN: That is not part of the cost

of the prescription?

MR. SAGE: No sir.

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accompany the supervisor to the pharmacy.

MR. RICE: Do they have the right of



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Sage

2022

mostly. That is about all the manufacturing we do.

THE CHAIRMAN: Watering down?

MR. SAGE: Yes, diluting.

THE CHAIRMAN: Diluting?

MR. BRYDEN: Do you do any tableting or anything like that?

MR. SAGE: We don't make tablets. We buy in bulk and sort into smaller boxes.

MR. BRYDEN: You don't actually make tablets?

MR. SAGE: No.

MR. RICE: Does the Ontario Hospital Services Commission check your system with regard to drugs, transferring, sorting, analysing, distributing of drugs, do they have any check on that at all?

MR. SAGE: Yes, they could have. I don't know that they do. They have a contact man who visits the hospital two or three times a year to check accounting and distributing costs and that sort of thing.

MR. RICE: Have you ever had any comments made to you with regard to any of these items?

MR. SAGE: Not specifically, just in general, drug costs are too high and going up every year.

THE CHAIRMAN: Do they object to that?

MR. SAGE: They don't like it.

THE CHAIRMAN: None of us like it.

-

-

-



mostly: This is the first time I have seen it.

THE CHAIRMAN: Watering down?

MR. SAGE: Yes, sir.

THE CHAIRMAN: Dipping?

MR. BRYDEN: Do you do any dipping or

anything like that?

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MR. RICE: We heard earlier from the Retailers' Association an average prescription I think it was \$3.30 last year. Is there any way of calculating what the average prescription at your hospital would be?

MR. SAGE: It is less than that. I mention in here somewhere a maximum of \$2 charge to clinic out-patients. At the time we established that we made a study and about 70% of our prescriptions are under \$2 actually.

THE CHAIRMAN: 70%?

MR. SAGE: 70% are under \$2; it cost us.

THE CHAIRMAN: And the other 30% Mr. Sage would go up to what?

MR. SAGE: Oh they go up pretty high Mr. Chairman, \$8, \$10, \$25, \$30 in some cases.

THE CHAIRMAN: When you get a prescription that would run in the bracket of \$7, \$8, \$9 what happens? You are the wrong person to ask this question. It should be your pharmacist. What do you do in the hospital? What happens in a hospital when you get a prescription that says \$8? Let's give an example, create an example. A high-cost prescription for a short run of two days, what do you do about it?

MR. SAGE: One question: to a clinic patient? To a private out-patient? He may be asked to pay the \$8. To a clinic patient ---

THE CHAIRMAN: That is perfectly obvious



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patient? To a private out-patient? He may be asked

to pay the \$8. To a clinic patient ---

THE CHAIRMAN: That is perfectly obvious



he would be asked to pay it, certainly. What about an in-patient?

MR. SAGE: An in-patient would never - just absorbed into the pharmacy cost.

THE CHAIRMAN: Is any report made to the hospital superintendent or the chief doctor about these prices?

MR. SAGE: Not a formal report by us, no.

THE CHAIRMAN: I am not saying the price is right or wrong.

MR. SAGE: No, we don't make it.

THE CHAIRMAN: Have you ever gone to one of the doctors and said "My gosh this is a high-priced drug", just like that? Have you personally?

MR. SAGE: No, I have never done it.

THE CHAIRMAN: You have never done it?

MR. SAGE: No.

THE CHAIRMAN: Have you ever seen a high price drug bill go through your hands?

MR. SAGE: No, I have heard of them.

THE CHAIRMAN: But you have not - if you have not seen them go through your hands it is obvious that you are not competent to answer the question so let's be specific.

MR. SAGE: All right.

THE CHAIRMAN: Have you ever had a high price drug bill go through your hands?

MR. SAGE: Many times Mr. Chairman.

THE CHAIRMAN: What did you do about it?



he would be asked to pay it, certainly. What about it?

MR. SAGE: An incident would never -

that absorbed into the program cost.

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MR. SAGE: All right.

THE CHAIRMAN: Have you ever had a high

price drug bill go through your hands?

THE CHAIRMAN: What did you do about it?



MR. SAGE: We tried to find a sponsor to pay for it.

THE CHAIRMAN: When you say "we" who is "we"?

MR. SAGE: The hospital, we in administration. We try to find---

THE CHAIRMAN: Who is "we"?

MR. SAGE: I.

THE CHAIRMAN: What did you do about it?

MR. SAGE: We try to find someone to pay for it and this goes back a good many years. We try to find a service club, someone who would take on the cost of a high price drug to a patient.

THE CHAIRMAN: Even though he is covered by the Hospital Scheme?

MR. SAGE: No. I am referring back some years.

THE CHAIRMAN: We are talking about in-patients under this scheme.

MR. SAGE: Now? No.

THE CHAIRMAN: Have you done anything about that?

MR. SAGE: No, I do nothing about that first-hand.

THE CHAIRMAN: Is it a right conclusion that if a high price drug goes through and the patient is under the Hospital Scheme you don't do anything about it? Is that right or wrong?



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MR. SAGE: We don't do anything about it, no.

THE CHAIRMAN: If it's a private patient who is going to absorb the bill? Is there any difference in what you do?

MR. SAGE: They are all covered by the Ontario Hospital Services Commission.

THE CHAIRMAN: All right, suppose they are not covered by the scheme?

MR. SAGE: They would just be billed the same as any other person. We don't always collect but we do bill them.

MR. RICE: Mr. Sage the Hospital for Sick Children received a questionnaire from this Committee some time ago did it and it made a return on that questionnaire?

MR. SAGE: That is right.

MR. SUTTON: Mr. Sage the Ontario Council for the College of Pharmacy has as a guiding principle the fact that no substitution is permitted. Now that is for any practising pharmacist. I realise that the hospitals are exempt but in the case of your hospital where your pharmacy is under the direct control of a registered pharmacist why is it that he would permit any substitution?

MR. SAGE: He has the authority of the Pharmacy Committee behind him.

MR. SUTTON: But he is a practising pharmacist in the Province of Ontario and he would be



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MR. SUTTON: But he is a practicing

pharmacist in the Province of Ontario and he would be



responsible to the Ontario Council of the College of Pharmacy. He would be disciplined directly wouldn't he?

MR. SAGE: I have not heard of this.

MR. RICE: Are there any other questions of Mr. Sage? You can step down Mr. Sage. Thank you very much. Perhaps we should have at this time Mr. Chairman Mr. McCray, chief pharmacist of the Hospital for Sick Children who could clear up some of these questions. Mr. McCray? Perhaps, first of all Mr. McCray you would give us any further information --

THE CHAIRMAN: Would he mind recording his full name.

MR. RICE: Would you record your full name please?

MR. McCRAY: Edward Rucastle McCray.

MR. RICE: What is your occupation?

MR. McCRAY: Chief pharmacist.

MR. RICE: Whereabouts?

MR. McCRAY: Hospital for Sick Children.

MR. RICE: That is located in Toronto here?

MR. McCRAY: Yes, University Avenue.

MR. RICE: How long have you been chief pharmacist?

MR. McCRAY: One year and ten months.

MR. RICE: What did you do prior to that time?

MR. McCRAY: I came to Canada four



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questions. Mr. McGray? Perhaps, first of all Mr.

McGray you would give us any further information --

THE CHAIRMAN: Would he mind recording

his full name.

MR. RICE: Would you record your full

name please?

MR. MCGRAY: Edward Rosalie McGray.

MR. MCGRAY: Chief pharmacist.

MR. RICE: Whereabouts?

MR. MCGRAY: Hospital for Sick Children.

MR. RICE: That is located in Toronto?

MR. RICE: How long have you been chief

MR. MCGRAY: One year and ten months.

MR. RICE: What did you do prior to

that time?

MR. MCGRAY: I came to Canada four



years ago and worked for two years with Drug Trading Company.

MR. RICE: Where did you come from?

MR. McCRAY: London, England.

MR. RICE: What did you do over in London, England?

MR. McCRAY: I was in a retail business for 21 years.

MR. RICE: What type of retail business?

MR. McCRAY: Pharmacy.

MR. RICE: You are a pharmacist by profession are you?

MR. McCRAY: Yes.

MR. RICE: Where did you receive your training?

MR. McCRAY: Edinburgh.

MR. RICE: What did that training consist of?

MR. McCRAY: My training consists of four years apprenticeship in pharmacy, one year course at the Harriet Watt College in Edinburgh from where I qualified.

MR. RICE: And what did you do with Drug Trading when you were here?

MR. McCRAY: I was in charge of narcotics and pharmaceuticals in their branch in London, Ontario.

MR. RICE: What do you mean in charge? What were your duties?



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MR. RICE: What do you mean in charge?

What were your duties?



MR. McCRAY: That was my nominal appointment. I did not purchase drugs, I simply controlled them and helped to distribute them and especially with reference to narcotics.

MR. RICE: Have you been associated with any hospital prior to your association with the Hospital for Sick Children?

MR. McCRAY: I had a small amount of work in the St. Joseph's Hospital in London, Ontario.

MR. RICE: Is that on a retail basis or was that attached right to the hospital?

MR. McCRAY: No, I went there as a dispenser.

MR. RICE: I understand that that hospital had at one time a retail drug pharmacy attached to it.

MR. McCRAY: Yes, that was before my time.

MR. RICE: Now there have been some questions of this power of substitution. Can you explain to the Chairman and members of the Committee just what power you have to substitute, in the Hospital for Sick Children, prescriptions and how it is exercised?

MR. McCRAY: If we received a prescription for a name brand drug, if we had been fortunate enough to purchase one of equal purity or same chemical constituent as the one that is named, we have under the powers of the administration which follow



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through the Pharmacy and Medical Advisory Committee authority to substitute one for the other.

MR. RICE: Who decides this equal purity?

MR. McCRAY: I beg your pardon?

MR. RICE: Who decides whether you substitute a drug of equal purity?

MR. McCRAY: We decide that from the specifications when we buy the drug.

MR. RICE: Is this a pre-decided matter? In other words has the Committee got together and pre-decided ---

MR. McCRAY: No.

MR. RICE: --- to substitute one drug for another or is it decided as the occasion arises?

MR. McCRAY: We can buy any substitute drug from any source of repute. We wouldn't substitute one from a firm that is not of repute. Knowing that, we anticipate that and we would get what we require.

MR. SUTTON: You 'phone the doctor back to get his permission?

MR. McCRAY: No, not necessarily, although in some cases we do.

MR. WREN: Are you registered with the College of Pharmacy?

MR. McCRAY: Yes.

MR. WREN: You don't feel that is a breach of ---



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MR. MCGRAY: Yes.

MR. WHINN: You don't feel that is a



MR. McCRAY: No, the College of Pharmacy has no jurisdiction over a pharmacist in a hospital.

MR. WREN: It wouldn't have jurisdiction over the pharmacy but they have jurisdiction over your registration of the pharmacist.

MR. McCRAY: Not if we are employed in the hospital pharmacy.

MR. WREN: Do you mean to say they couldn't take away from you the right to practise?

MR. McCRAY: They could but not as ---

MR. WREN: In a hospital I mean.

MR. McCRAY: Not for substituting a drug. That wouldn't be considered an offence.

MR. RICE: Mr. McCray do you consult anyone before you exercise your power of substitution?

MR. McCRAY: Not necessarily because the power has already been given by the hospital administration and we operate under that practice.

MR. RICE: Is there anyone else besides yourself who has this power of substitution?

MR. McCRAY: Yes, any of the pharmacists under my control.

MR. RICE: Do they consult with you before they exercise that control?

MR. McCRAY: Not in every case. They are not required to do so.

MR. RICE: How many pharmacists have you under your control?

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MR. RICE: How many pharmacists have

you under your control?



MR. McCRAY: Six.

MR. RICE: And are they all registered with the Ontario College of Pharmacy?

MR. McCRAY: No, they are not.

MR. RICE: How many are registered with the Ontario Pharmacy?

MR. McCRAY: Four. I beg your pardon, four including myself.

MR. RICE: And then there are two unregistered ones?

MR. McCRAY: Three.

MR. RICE: Three unregistered ones. What qualifications have they?

MR. McCRAY: They are pharmacists from another country.

MR. RICE: They are all registered pharmacists in some other country?

MR. McCRAY: Yes, they are.

MR. RICE: What other countries do they come from?

MR. McCRAY: Australia, England and Finland.

MR. RICE: Are they working towards becoming registered pharmacists in Ontario?

MR. McCRAY: Two of them have been apprenticed to me with that object in view.

MR. RICE: How much longer do they have to go before finishing their apprenticeship?

MR. McCRAY: One has already sought the



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examination and the other anticipates doing so.

MR. RICE: Now perhaps Mr. McCray you could help us in this regard, if you could. We here, of course, are interested in prescription cost.

MR. McCRAY: Yes.

MR. RICE: And could you take a typical prescription, take the one that is in regulation 15 here, Meticorten, and some similar examples, and could you tell us what a typical prescription cost of that would be to an in-patient in your hospital; secondly, to an out-patient in your hospital and thirdly, if you could because you are associated with the business, what that typical prescription cost in your retail store is?

MR. McCRAY: Yes. A prescription for 100 tablets of the Meticorten, five grain, whether prescribed by so-called generic name or otherwise, would cost \$2.50 including the 10% mark-up.

MR. RICE: Who is that to now?

MR. McCRAY: That is to an in-patient.

MR. RICE: That goes on the Ontario Hospital.

MR. McCRAY: To an out-patient, if an out-patient was entitled to benefits they would not have to pay more than \$2, owing to the financial circumstances. They would pay up to the \$2 and we would pay the rest. If their financial circumstances have decided that, they would have to pay the \$2 difference.

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have decided that, they would have to pay the \$2



THE CHAIRMAN: Who pays the 50 cents?

MR. McCRAY: The hospital absorbs that.

THE CHAIRMAN: The hospital absorbs it?

MR. McCRAY: Yes.

MR. RICE: Could you tell us what that type of prescription would cost, on the average, in a drugstore?

MR. McCRAY: Yes, 100 tablets would cost \$22.70 not including the dispensing fee.

MR. RICE: \$22.70 for the same prescription?

MR. McCRAY: Yes.

THE CHAIRMAN: For 100 tablets.

MR. McCRAY: 100 yes. I quoted that because it illustrates the importance of negotiation between the chief pharmacist, and the purchasing agent and the detail men.

MR. WREN: Just before you get away from that, that 50 cent charge which is absorbed by the hospital, does the Ontario Hospital Services Commission recognise that as part of the cost?

MR. McCRAY: Well that doesn't come really into my jurisdiction. I should have to ask Mr. Sage that question.

MR. SAGE: The answer is no Mr. Chairman.

MR. WREN: That is a loss, unless some donor ---

MR. SAGE: That is a loss.

MR. RICE: Just to get this clear, this



THE CHAIRMAN: Who pays the 50 cents?

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THE CHAIRMAN: The hospital absorbs it?

MR. MCGRAW: Yes.

MR. RICE: Could you tell us what that

type of prescription would cost, on the average, in

a drugstore?

MR. MCGRAW: Yes, 100 tablets would cost

\$22.70 not including the dispensing fee.

MR. RICE: \$22.70 for the same prescrip-

MR. MCGRAW: Yes.

THE CHAIRMAN: For 100 tablets.

MR. MCGRAW: 100 yes. I quoted that

because it illustrates the importance of negotiation

between the chief pharmacist, and the purchasing agent

and the detail man.

MR. WREN: Just before you get away from

that, that 50 cent charge which is absorbed by the

hospital, does the Ontario Hospital Services Commission

recognize that as part of the cost?

MR. MCGRAW: Well that doesn't come

really into my jurisdiction. I should have to ask Mr.

Sage that question.

MR. SAGE: The answer is no Mr. Chairman.

MR. WREN: That is a loss, unless some

donor ---

MR. SAGE: That is a loss.

MR. RICE: Just to get this clear, this



\$22.70 figure that is for the same quantity and quality already dispensed to the in-patient at \$2.10 and the out-patient for \$2.50. On top of that \$22.70 you say there could be a prescription fee?

MR. McCRAY: Yes, some pharmacists would charge that; others might not.

MR. RICE: Of course your cost to the in-patient and the out-patient would not include any overhead or salaries?

MR. McCRAY: None at all, no.

MR. SUTTON: Does the whole department operate at a loss or are there other prescriptions where you make it up?

MR. McCRAY: The whole department is operated at a loss.

MR. RICE: Is this example you have given us typical or is it extraordinary?

MR. McCRAY: No, it is not typical. It's extraordinary.

MR. RICE: Give us a typical example. We don't want any extraordinary ones.

MR. McCRAY: Well take gantissin in suspension. We dispense a 4-ounce bottle of that, consisting of 32 doses, for \$1.

MR. RICE: Is that to an in-patient or out-patient?

MR. McCRAY: To both. That is the cost, including the 10% surcharge. I am not in possession of the retail price but I should think it

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\$22.70 figure that is for the same quantity and



might be twice that.

MR. RICE: Is that one of the lower differentiations?

MR. McCRAY: That is a more typical differentiation.

MR. RICE: And the \$2 retail price there would that amount have the prescription fee in it?

MR. McCRAY: I wouldn't like to say that because I don't know the retail price. That was just - I know it isn't as high as the Meticorten figure.

MR. RICE: We can appreciate Mr. McCray that you are only giving your own experience in your retail price here. Are there any other questions?

MR. WREN: When you say your department is operated at a loss does the loss occur before you consider salaries and overhead or after?

MR. McCRAY: Not being an accountant, I wouldn't know how that is accounted but in my way of thinking, if we do not sell drugs at a profit, except a nominal profit of 10%, an amount that you have to mark overhead for your department, which is very high in relation to the overhead of the whole hospital, I should say it is obvious that we are not making a profit.



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MR. WREN: Does the 10% surcharge cover the cost of the drugs without loss?

MR. McCRAY: No it does not.

MR. TROTTER: Do you find that the detail men from drug companies take a great deal of your time?

MR. McCRAY: No they do not, because we allocate time for them to call, and in general they don't subject us to any pressures. They come and state their case and tell us what they have, and generally we are agreeable to listen to them.

MR. TROTTER: Could you give me an idea of the number of interviews you have in a week with detail men?

MR. McCRAY: Yes, probably not more than 20.

THE CHAIRMAN: Mr. Trotter, isn't that like asking a politician how many people come to him and bring their problems to him, and some of them have merit and some do not?

MR. TROTTER: Throughout the hearing of this Committee we have at some length questioned on detail men, and this question has been asked consistently of each witness.

THE CHAIRMAN: I agree with it, and I am not criticizing you, but I am suggesting that if there were 188 detail men with merit bringing a wholesome idea, it would be a good thing for the hospitals to have 188 interviews.

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MR. WREN: Does the 10% surcharge



MR. TROTTER: Yes, that could be true.
We don't know yet, at least I don't know in my own
mind --

THE CHAIRMAN: Let's face it, we will
never know what the merit is, but the fact is that
anybody who is of a progressive state of mind would
be interested in listening, wouldn't he?

MR. TROTTER: That is right.

MR. PRICE: Do you approve of the policy
of the Pharmacy Committee of permitting one product to
be substituted for another?

MR. McCRAY: Yes I do.

MR. PRICE: Has there been any opposition
to this by the doctors?

MR. McCRAY: Only in one or two cases where
a new resident has not been aware of the system.

MR. PRICE: Only in those cases?

MR. McCRAY: Yes.

MR. WREN: That applies to Out-Patient
prescriptions as well?

MR. McCRAY: Yes.

MR. WREN: It does?

MR. McCRAY: Yes.

THE CHAIRMAN: Well, when a doctor is on
the staff of your hospital, he has to agree to the rules?

MR. McCRAY: Yes he does. In a way he is
subject to the rulings of the Medical Advisory Committee.

MR. WREN: Are all out-patient prescriptions
issued only by staff doctors?

MR. TROTTER: Yes, that could be true.

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MR. McCRAY: No they are not.

MR. WREN: They can be issued by any physician?

MR. McCRAY: By residents too.

MR. WREN: Staff doctors and resident interns too?

MR. McCRAY: Yes.

THE CHAIRMAN: Who controls the patient?

MR. McCRAY: Well, I don't know how --

THE CHAIRMAN: Let us get down to fundamentals. A child comes into the hospital. Who sponsors it?

MR. McCRAY: It is sponsored by its parents or relatives.

THE CHAIRMAN: No, in a medical sense.

MR. McCRAY: Well, it would be taken to the clinic to which it has applied, and then a doctor or an intern in charge is responsible for the patient.

THE CHAIRMAN: But that doctor or intern is attached to the hospital. Let us get the record straight. A child comes into your hospital. Forget the parents and think of the medical side. That child is sponsored by a doctor of record on your hospital staff, or an intern?

MR. McCRAY: Yes.

THE CHAIRMAN: And he then assumes that doctor, an accredited doctor on your staff?

MR. McCRAY: That is so.

THE CHAIRMAN: He then takes over?

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MR. McCRAY: Yes.

THE CHAIRMAN: So then the doctor who assumes the supervision of the treatment of the patient then carries on?

MR. McCRAY: That is correct, yes.

THE CHAIRMAN: And I might be a doctor accredited to another hospital, but without standing at your hospital?

MR. McCRAY: That is the case.

THE CHAIRMAN: And I would have no jurisdiction, and have no right to prescribe in your hospital?

MR. McCRAY: I don't know that question, the answer to it. May I refer to Mr. Sage?

THE CHAIRMAN: Mr. Sage, what would you say about that?

MR. SAGE: I am sorry, I didn't hear the question.

THE CHAIRMAN: Never mind, I will get it from another witness. You know what I am talking about Mr. Sage just as well as I do.

MR. SAGE: I am sorry sir, I was reading in my brief.

THE CHAIRMAN: Well, what we are talking about cannot be of too much interest to you.

MR. SAGE: Don't be so rude to me sir.

THE CHAIRMAN: I am not rude to you at all.

MR. SAGE: Well, if you repeat the question I will try and answer it.

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THE CHAIRMAN: All right, I will get the answer from another witness.

MR. SAGE: There is so much you can take and no more. Just take it easy.

THE CHAIRMAN: What was that?

MR. SAGE: Take it easy, you are pretty rough.

THE CHAIRMAN: You are here as a representative of one of Canada's outstanding hospitals.

MR. SAGE: I am trying to be that.

THE CHAIRMAN: And we are asking about the responsibility of a doctor with respect to a patient in your hospital. I think that is a pretty important matter.

MR. SAGE: That is right.

THE CHAIRMAN: And we are talking about an accredited doctor on your staff, and there are doctors who are accredited and others who are not in any one hospital?

MR. SAGE: No, we don't have such a terminology. There is no such thing as a non-accredited doctor. They are either on the staff --

THE CHAIRMAN: But there are doctors who cannot go in your hospital and treat and give directions with respect to a patient?

MR. SAGE: That is right, they are not on our staff.

THE CHAIRMAN: So, without any inference being implied of a positive or negative nature, they are



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either accredited or not accredited on your staff. Is that not so?

MR. SAGE: If they are not on our staff they are not accredited.

THE CHAIRMAN: That is what I mean. So they couldn't give orders with respect to the treatment of a patient?

MR. SAGE : No sir.

THE CHAIRMAN: And that applies to other hospitals. It is not just your hospital. It applies to every hospital does it not?

MR. SAGE: I thought for a moment you were referring to what we call courtesy staff in some hospitals, as distinct from full-time staff, and we don't have a group of doctors called courtesy doctors.

THE CHAIRMAN: If I were a doctor not on your list, I couldn't go in and take my patient in your hospital and prescribe for him. That is what I am getting at.

MR. SAGE: That is right.

THE CHAIRMAN: There is no criticism there, Mr. Sage, and you need not take any offense at it.

MR. SAGE: I won't.

THE CHAIRMAN: That applies to every hospital, and if you took your child to a certain doctor you might not be able to have that child in a certain hospital and give him treatment, is that not so?



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MR. SAGE: He couldn't, no, but he can refer him to a colleague.

THE CHAIRMAN: He would have to refer him to someone who is on your staff at your hospital?

MR. SAGE: That is right.

THE CHAIRMAN: Or any hospital?

MR. SAGE: That is correct.

THE CHAIRMAN: That applies to adult patients as well does it not?

MR. SAGE: Yes.

THE CHAIRMAN: Of course it does, and that situation is one in which the public is interested, are not they, because they don't understand it, and it seems to me it is a good idea to air it and bring it out in light. There is no criticism one way or the other, but the fact is that if you wanted your brother, your daughter, your sister or your wife, or uncle taken to a certain hospital with a certain doctor, you might not be able to accomplish that?

MR. SAGE: That happens quite frequently.

MR. WHITNEY: In page one of your brief, you state that for the rated capacity of 647 beds, there are six pharmacists, not including the Chief Pharmacist, who prepare an average of 413 prescriptions every day, allocate supplies to 21 wards, and manufacture a large number of solutions and ointments so essential to the care and treatment of 600 sick children. You explain that a portion of your time is spent in meeting detail men et cetera. What portion of your time would actually



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MR. MCCRAY: Very little indeed, unless I go at weekends to do back work.

2

MR. WHITNEY: Then six pharmacists, in addition to filling 413 prescriptions each day, that would be an average of approximately 69 prescriptions a day filled by each of your pharmacists, in addition to doing these other duties, manufacturing solutions and ointments, allocating supplies to 21 wards et cetera, each and every day on an average?

MR. MCCRAY: Yes.

MR. WHITNEY: We have had representatives from the Retail Druggists' Association who have expressed the opinions that the pharmacist can only actually fill an average of about 35 prescriptions a day, that that would be the limit. Some could be filled quickly, but others would be so complicated that he couldn't possibly on an average fill more than 35 prescriptions per day. Therefore, in this case in addition to the other duties that your six pharmacists are doing, they are also filling approximately twice that number of prescriptions a day, and I was wondering if you would have any comments on that?

MR. MCCRAY: Well, in my estimation that is well within the capacity of our pharmacists, because we take care when we pick them that they are able to do the work. We feel they are highly qualified, either in this country or another. If they were not, they would stay there. They are under supervision, and



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I can tell you they can do this work quite easily.

MR. WHITNEY: So it is possible that pharmacists in the pharmacist's store, would you suggest that they might be engaged in other work, in addition to the filling of prescriptions?

MR. McCRAY: No, it is not that. In a retail drug store a prescription is handed over the counter, it has to be given to a pharmacist to dispense who may be doing something else. It has to be serial numbered, it has to be labelled, a receipt given out for it. It has to be priced and then wrapped up, and then the money taken for it. That takes approximately twice as long as it does in a hospital pharmacy. A lot of the written work is eliminated.

MR. WHITNEY: That is very interesting thank you.

MR. BOYER: Would you say in addition to that that a retail pharmacy would dispense a greater variety of prescriptions than a hospital pharmacy?

MR. McCRAY: Not necessarily. It would depend on the pharmacy.

MR. BOYER: Would there be a relatively limited variety of prescriptions in a hospital?

MR. McCRAY: No, because new drugs are being discovered and used every day.

MR. BOYER: There would be very little difference on that account?

MR. McCRAY: I would say there is a bigger variety used in the hospitals. --



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MR. PRICE: If the policy of the Pharmacy Committee was not as it is now, do you not feel that the doctors would prefer to have the prescriptions filled exactly as directed?

MR. McCRAY: I would say if the doctors were unaware of the equivalent to be found in some of the drugs, they would prefer to have it filled as prescribed.

MR. PRICE: What we have heard up to now, doctors have that preference.

MR. McCRAY: They do in the retail work; they prefer to have exactly what is prescribed, dispensed.

MR. FULLERTON: Are you on the Purchasing Board for the hospital?

MR. McCRAY: No, I am not on the Board, but I collaborate with the purchasing agent .

MR. FULLERTON: Who is he?

MR. McCRAY: Mr. Morgan.

MR. FULLERTON: Do they buy from Drug Trading?

MR. McCRAY: In very little quantity.

MR. FULLERTON: Have you any idea of the percentage?

MR. McCRAY: I should say less than 2%.

MR. FULLERTON: Do they tender on these drugs as well as the other suppliers?

MR. McCRAY: Drug Trading do not tender. It would be incidentals which we require. This is also done in the same way from the National Drug

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MR. PRICE: If the policy of the Pharmacy



Company.

MR. WREN: Does any supplier provide a significant portion of the supplies?

MR. McCRAY: Not wholesale supply as we know it, that is a chemist wholesale, no. We buy chiefly from manufacturers direct.

MR. WREN: Who is that?

MR. McCRAY: I could name Parke-Davis, Frosst, A.S. McKenna, Ledderle, and others too numerous to mention.

MR. WREN: Would any one of those have any significant percentage of that business?

MR. McCRAY: Yes, I would say that Frosst, Parke-Davis occupy a very large part of it.

MR. SUTTON: This matter of control of drugs, would you consider employing an independent analyst?

MR. McCRAY: If I considered it necessary I would.

MR. SUTTON: To enlarge the number of reputable firms.

MR. McCRAY: How many would you like me to name, sir?

MR. SUTTON: The statement came out that you only buy the drugs from those firms that you consider reputable, and then there was quite a discussion as to how you consider them reputable. I believe the cost, if you set up your own controls, would run \$30,000.00 a year, but if you ran a spot

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MR. WREN: Would any one of those have

Frost, A.S. McKenna, Ledgerle, and others too numerous

MR. MCGRAY: I could name Parke-Davis,

MR. WREN: Who is that?

chiefly from manufacturers direct.

know it, that is a chemist wholesale, no. We buy

MR. MCGRAY: Not wholesale supply as we

significant portion of the supplies?

MR. WREN: Does any supplier provide a

Company.



check occasionally and employed an independent chemical company which specialized in making spot checks -- we had one man here, Gilbert, and he had one firm.

MR. McCRAY: I believe it could be done.

MR. SUTTON: An expenditure of \$274,000.00 for the hospital, would it be worthwhile for the hospital to make spot checks?

MR. McCRAY: I think it would.

MR. WREN: How do you determine a supplier who wouldn't be satisfactory?

MR. McCRAY: Well, generally speaking, in the drug trade firms of repute are household words, their reputation is as important to them as their drugs, and they are not likely to supply an inferior drug because their livelihood depends on it.

MR. WREN: How would you determine whether a young group going into the business was a safe group to deal with or not?

MR. McCRAY: We would not be able to determine that at all, not under our present arrangement.

MR. WREN: So that the situation as it obtains now, if we had a partnership or a company consisting of young Canadian wanting to sell you drugs, you for safety's sake would purchase from a firm with a known reputation.

MR. McCRAY: The tendency would be that way. But it wouldn't exclude them, because if they offered proof of satisfactory controls we would be inclined to accept it, but it may be necessary to



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MR. McCRAY: I believe it could be done.

MR. SUTTON: An expenditure of \$25,000.00

for the hospital, would it be worthwhile for the hospital to make spot checks?

MR. McCRAY: I think it would.

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apply spot checking.

MR. WREN: If I were to come to you and say I was engaged in the manufacture of drugs, would I receive a cordial hearing and an opportunity to present my case?

MR. McCRAY: You certainly would, yes.

MR. WREN: What would you do?

MR. McCRAY: I should ask for the name of the drug and what it consists of, also clinical evidence that it had been tested, and if it came to a question that it was really a seriously discussed point of view of buying, we should want evidence of purity.

MR. PRICE: Have you had any occasions to have drugs disappear as the result of theft from the hospital?

MR. McCRAY: Not in my experience, and I can't speak for anyone else's because I don't know.

MR. RICE: Mr. McCray, are there any firms you would consider not reputable, not satisfactory to purchase from?

MR. McCRAY: Yes, but I wouldn't like to name them.

THE CHAIRMAN: I think that is a fair answer.

MR. WREN: What I am interested in is how would you ascertain that they were unreputable. What tests did you apply to ascertain that they were unreputable?

MR. McCRAY: From reports I have heard



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from other people generally; not necessarily from other detail men.

MR. WREN: Largely hearsay?

MR. McCRAY: Yes.

MR. RICE: Have you had any experience of drugs going bad or poor quality?

MR. McCRAY: Not in the Hospital for Sick Children. They occasionally go out of date, because they must.

MR. PRICE: Would you be influenced by anything you might have heard from doctors?

MR. McCRAY: Yes.

MR. PRICE: Lacking in quality control.

MR. McCRAY: Those things are discussed at the Pharmacy Committee meetings.

THE CHAIRMAN: I suppose, Mr. Price, it would be that if anyone in a purchasing capacity in a hospital failed to heed anything he heard with respect to drugs for patients, then he would be negligent by himself, by his own act. He couldn't afford to ignore it. There is the other side of that. It may be poor evidence, it may be hearsay, but he would be negligent if he ignored it.

MR. WREN: Doctors are sometimes driven by emotions.

THE CHAIRMAN: I guess we are all driven by emotions.

MR. WREN: If you had no ordered procedure -- for instance, you might consult the Food



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and Drug people, you might ask for an analysis.

MR. McCRAY: We have a conservative policy with regard to buying in that we are not inclined to take risks in the quality of drugs.

THE CHAIRMAN: What actually we are approaching -- you are opening up the whole field -- is that on the one hand we say why should you ban anyone from tendering or buying from them; on the other hand, if you went ahead and did buy and you heard something, and even whatever the price differential was, the differential would be insignificant to the whole picture, and yet the purchasing department would be negligent if it didn't take any notice.

MR. WREN: They don't investigate, they accept an opinion, no doubt from a qualified medical practitioner, but they accept that opinion. If he casts some doubt on the strength, purity and quality control of the drugs, that would be sufficient to keep it out of your dispensary?

MR. McCRAY: Yes, if a doctor said that it would be tantamount to saying that he hasn't any faith in it.

MR. FULLERTON: They accept hearsay on top people like the Frosst Company, but they accept hearsay to condemn another company.

THE CHAIRMAN: Let's be practical about it. If you are going to buy fish and chips from one store and the price is the same and somebody said they got a bad lot of fish and chips, you are going



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to go to the other store, because there is not that much difference, you are going to avoid the chance of a poor product. Isn't that about it?

MR. RICE: Any further questions?

THE CHAIRMAN: Just to summarize what you said, Mr. McCray, the total purchasing of the Hospital for Sick Children amounts to what in the year?

MR. SAGE: Drugs, \$274,000.00 in 1960.

THE CHAIRMAN: And the total budget out is what in the year, everything?

MR. SAGE: Approximately six million dollars.

THE CHAIRMAN: Would that be, Mr. McCray, a relatively constant factor, \$274,000.00 against six million?

MR. McCRAY: My experience of hospital accounting is very limited. I wouldn't care to offer an opinion.

THE CHAIRMAN: That would be 1/24 in round figures of the total budget for prescription drugs?

MR. SAGE: It is about 4%.

THE CHAIRMAN: Would that be your experience, Mr. Sage? Would that be fairly accurate across the board of hospital prescription drugs against budgets, 4%?

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THE CHAIRMAN: Would 4% of the hospital budget be applied to prescription drugs? Would that be about it?

MR. SAGE: That is about it right now. It seems to be rising.

THE CHAIRMAN: And 4% is absorbed by the Hospital Services Commission to the factor or percentage which exists, which is 94% or 95%?

MR. SAGE: Very close.

THE CHAIRMAN: So 95% of 4%; is that it?

MR. SAGE: Practically all of it is paid by the Commission.

THE CHAIRMAN: Do you see any benefit, Mr. Sage, from your experience as an operator of the business, do you think that out-patients' clinics are desirable things?

MR. SAGE: Oh, I do indeed, sir. We have an average of 325 children come into our clinic every day. Otherwise they would be admitted in many cases, and there wouldn't be room in any hospital to accommodate them.

THE CHAIRMAN: We understand that the out-patient clinic factor is not a large factor in the business we are talking about.

MR. SAGE: No, not a large factor, certainly not in cost, not a large percentage of the overall costs.



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dw THE CHAIRMAN: Would you go along with me, would you agree that matter is not a prevalent or existing factor, it is just in the large hospitals where it exists?

MR. SAGE: That is right.

THE CHAIRMAN: Do you think it is an avenue of opportunity where the public can be served if we had more out-patient facilities? I am having in mind all our Committee and all the drugs factor, the out-patient facilities involving the right to buy prescription drugs.

MR. SAGE: I would think so, I would think that that is the answer to many in small city hospitals. You find an out-patient department in large centres. It is often - I think it might well be extended to your smaller cities to stop this 100%.

THE CHAIRMAN: It would have a deferring factor, deferring effect on the bed occupancy situation.

MR. SAGE: I would judge so.

THE CHAIRMAN: On the one hand and if you went to the other side you would think there might be a benefit to the citizen himself.

MR. SAGE: That depends.

THE CHAIRMAN: In being able to go back to the hospital pharmacy.

MR. SAGE: Yes, it would be a benefit if they could get it less expensively. If you are speaking of the average Joe Citizen whose salary is low where he could get into a clinic without paying a



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fee, that is a financial benefit. If it is an out-patient clinic where a group of doctors serve and charge fees for every patient they see, there would be no advantage from the public standpoint. When you say clinic, in my thinking it means free service. That may not be what you have in mind.

THE CHAIRMAN: I am thinking purely, I am not thinking of the free medical side, I am thinking of the drug prescription side.

MR. SAGE: If the clinic sold its drugs at cost there would be a definite saving.

THE CHAIRMAN: Have you ever run into cases of hardship, Mr. Sage?

MR. SAGE: A lot.

THE CHAIRMAN: What do you do about them?

MR. SAGE: We don't charge them, if that is what you mean, yes, it is welfare.

THE CHAIRMAN: Have you ever seen any doctor who said, look, I will take this fellow over, this poor fellow cannot afford drugs?

MR. SAGE: Not with my personal knowledge. I daresay it isn't too frequent.

THE CHAIRMAN: Have you ever run into that with a doctor, where he would say, look, you fellows at the hospital, forget about it, I will take on this situation. I will look after it.

MR. SAGE: I can't say that I have.

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MR. SAGE: I can't say that I have.

THE CHAIRMAN: Have you ever seen a drug



manufacturer, obviously through a detail man or some representative, say this is a tough case, we will let them have it?

MR. SAGE: Yes, that has happened in our hospital.

THE CHAIRMAN: It has?

MR. SAGE: Yes.

THE CHAIRMAN: So we will identify what we are talking about, we are talking about high price drugs and a patient who cannot afford to pay for them.

MR. SAGE: We do have suppliers who actually provide us with certain drugs that we are honour-bound to deliver only to recognised or registered welfare cases like mother's allowance cases, that sort of thing. They give us drugs. It is a common thing.

THE CHAIRMAN: Would that be limited to one company?

MR. SAGE: Three or four, from memory.

THE CHAIRMAN: Does it happen often, Mr. Sage?

MR. SAGE: Yes, it happens regularly. Even though the Commission pays the cost of drugs, that still applies. Back in the days when we had to find money to run the out-patient department and the in-patient department deficit, this was a great boon to our welfare people. It is today.

THE CHAIRMAN: Is that a standard arrangement or when the occasion arises do you have



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THE CHAIRMAN: Is that a standard

arrangement or when the occasion arises do you have



to approach the company that manufactures the particular drug?

MR. SAGE: Frequently they offer it knowing we do have a tremendous number of children who just cannot pay for anything.

THE CHAIRMAN: Is that, say, on a research basis?

MR. SAGE: Not exactly research, just our own administrative staff run into or whenever they find a financial strain on the patient it is referred to us.

THE CHAIRMAN: What I am getting at, do you report the result to the company or is it a straight benevolent gift?

MR. SAGE: It is a gift, and the usage would be determined, the extent of it, how often we should get more.

MR. PRICE: Can you give us some idea of what the value of the drugs given in this way might be in the course of say a 12-month period?

MR. SAGE: I am afraid I can't, sir.

MR. PRICE: Would it be small or large?

MR. SAGE: I think it would be small in comparison to the total dollars we spend on drugs. It might add up.

MR. RICE: Any further questions?

THE CHAIRMAN: Thank you, Mr. Sage.

MR. RICE: We still have three witnesses to hear from this afternoon.



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THE CHAIRMAN: Thank you, Mr. Sage.

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es to hear from this afternoon.



THE CHAIRMAN: Do you want to proceed gentlemen? It is up to the Committee. Do you want to proceed the hearing? Are there any from out of town?

MR. RICE: All from out of town.

THE CHAIRMAN: Mr. --?

MR. SMITH: Smith, Woodstock.

MR. APPLEYARD: Hamilton.

THE CHAIRMAN: Well, Mr. Secretary, what do you suggest?

THE SECRETARY: We have four more tomorrow, sir from Leamington, Ingersoll and Toronto.

THE CHAIRMAN: What is the convenience of these gentlemen who are here today?

MR. SMITH: I would prefer to go on this evening. I have to be in London tomorrow.

THE SECRETARY: Perhaps you could have the brief and leave the questioning.

MR. TROTTER: If the men are from out of town perhaps we should sit.

THE CHAIRMAN: There are two sides to the coin, as you know. You gentlemen have probably learned something today from the nature of the questioning which might affect the presentation that you want to make. By the same token we cannot delay you here in Toronto. We would be prepared to go on and hear you. There are some benefits if we defer your hearing until a later date. Our pleasure is your convenience, let me put it that way. I am prepared



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MR. APPELBYARD: Hamilton.

THE CHAIRMAN: (to Mr. Appelbyard)

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to stay here until midnight.

THE SECRETARY: We could go over to next week or into July.

THE CHAIRMAN: Mr. Trotter, have you any observations? I see that Mr. Bryden has departed.

MR. TROTTER: Perhaps they could present their brief.

THE CHAIRMAN: Who is first, Mr. Smith?

THE SECRETARY: Mr. Smith from Woodstock.

MR. WREN: Could we take this brief as read, put it in the record. These gentlemen represent hospitals of the type I would certainly like to question. There wouldn't be time today.

THE CHAIRMAN: Let us take Mr. Smith. We will read his brief, the purple, into the record. You would like to question?

MR. RICE: The next is Mr. Don MacKay from Peterborough, Group B Hospital.

THE CHAIRMAN: Mr. MacKay?

MR. MacKAY: Yes sir.

THE CHAIRMAN: And the third gentleman is who?

MR. RICE: Dr. Appleyard from Hamilton.

DR. APPELYARD: It makes no difference to me. I will come back another day.

THE CHAIRMAN: There is the situation. What is your pleasure?

MR. SUTTON: We had better sit till 6 o'clock anyway and see how many we can get through.



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o'clock anyway and see how many we can get through.



THE CHAIRMAN: And I said there are two sides to the coin. There is an advantage to staying by way of courtesy to you gentlemen, which we will do and there are also advantages to you to come back at a later date.

DR. APPELYARD: I would appreciate if I could return. I think I might be able to brush up a little in my brief. I would appreciate it.

THE CHAIRMAN: Dr. Appleyard is from Hamilton and he is prepared to come back.

MR. MacKAY: I will come back.

THE CHAIRMAN: Mr. Smith, would you like to go ahead and comment on your brief? I am trying to meet your pleasure.

MR. SMITH: I could come back any day but tomorrow.

THE CHAIRMAN: Do you want to go on and comment on your brief or would you rather come back?

MR. SMITH: I would rather come back. May I have my brief back or do you want to read this brief in?

THE CHAIRMAN: You may have your brief back.

MR. RICE: You made a comment that the brief was to be taken into the record as read.

THE CHAIRMAN: Would you rather withdraw your brief?

MR. SMITH: Yes, if I am going to return.



THE CHAIRMAN: And I said there are two

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THE CHAIRMAN: You may have your brief

MR. RICE: You made a comment that the

brief was to be taken into the record as read.

THE CHAIRMAN: Would you rather withdraw

your brief?

MR. SMITH: Yes, I would like to withdraw



THE CHAIRMAN: Mr. Smith's brief is withdrawn.

Are there any other appearances or submissions or representations to be made today?

I think it should be made abundantly clear, and I am sorry Mr. Sage and his friend have departed, no one is on trial before this Committee at all, but we are interested in getting information about the procedures and the purchasing and the policies and all these things, and the right of prescribing and all these things that have to do with the cost of drugs. Anything that you gentlemen from the hospital side can make available to us will assist the Committee because actually the hospital side is a major part of the terms of our reference. It is not the full side, but it is a very important side having to do with procedures because that is where a large portion of the public money goes in drugs in this Province, to the hospitals.



THE CHAIRMAN: Mr. Smith's brief is

withdrawn.

Are there any other appearances or

submissions or representations to be made today?

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You only need to take the percentage of coverage in the Hospital Services Commission, whether it be 94 or 95% and there it is so that means that 94% of all the drug bills in all hospitals in Ontario have to do with the public purse. I would think that this Committee's enquiry is running parallel to the Hospital Services Commission on this subject having to do with the costs and the control, and those things that are borne by the Provincial Government and that is why we are interested in it.

I might say it distresses me somewhat to find any resistance on anyone's part who might come before this Committee because no one is under trial; no one is charged with anything; just trying to help ourselves on this subject. I think that is a fair statement of fact. Now do you have anything to add Mr. Price?

MR. PRICE: No.

THE CHAIRMAN: Mr. Wren?

MR. WREN: No.

THE CHAIRMAN: Mr. Trotter?

MR. TROTTER: No, nothing.

THE CHAIRMAN: Mr. Sutton?

MR. SUTTON: No.

THE CHAIRMAN: Mr. Boyer?

MR. BOYER: No.

THE CHAIRMAN: Mr. Whitney?

MR. WHITNEY: No.

THE CHAIRMAN: Mr. Fullerton?



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MR. WERN: No.

THE CHAIRMAN: Mr. Sutton?

MR. SUTTON: No.

MR. BOYER: No.

THE CHAIRMAN: Mr. Sutton?



MR. FULLERTON: No.

THE CHAIRMAN: With those words we will
adjourn until tomorrow at, let's say, 2.15.

--- Hearing adjourned at 5.30 p.m.

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MR. FULLERTON: No.

THE CHAIRMAN: With those words we will

--- Hearings adjourned at 2.30 p.m.

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Mr. K. Bryden

Select Committee on Drugs

HEARINGS

HELD AT

PARLIAMENT BUILDINGS

TORONTO ONTARIO

VOLUME No.:

21

DATE:

JUNE 13 1961

OFFICIAL REPORTERS

ANGUS, STONEHOUSE & CO. LTD.

372 BAY STREET

TORONTO

EM. 4-7383

EM. 4-5865



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

SOME ERRORS NOTED IN TRANSCRIPT OF HEARING OF

SELECT COMMITTEE ON DRUGS, JUNE 13TH, 1961

Volume 21

- Page 2101 Paragraph 2, line 5-----This was before Pasteur, who discovered the existence of bacteria, and then Lister brought in antiseptics such as carbolic, used in the form of a spray, and then we had asepsis ----
- Page 2113 Paragraph 7, line 4 ----- Now, these are not just ex-officio members.
- Page 2114 Paragraph 2, line 3 -----if you call that tendering, but it's not my interpretation of tendering-----
- Page 2118 Paragraph 5, line 1----- I think they should be run in the manner of the Public Auditors' office, above reproach, so to speak. And line 5-----but I think when it is privately controlled, perhaps by a manufacturer-----
- Page 2120 Paragraph 1, line 4-----and we mentioned aspirin, that is the trade name, that is acetylsalicylic acid-----
Paragraph 3, line 2-----is quite a number of drugs you could purchase this way,
- Page 2121 Paragraph 3, line 4-----digitalis and so on, and alkaloidal extracts from drugs, and line 7-----is this other 50% we cannot project, as we don't know what-----
- Page 2122 Starting on the first line on the page:---- tablets. We called the doctor back and asked if there was anything similar he might use. We mentioned one or two drugs we happened -----
- Page 2124 Paragraph 1, line 3 -----chemicals used in all the departments of the hospital
- Page 2125 Paragraph 1, last line----- local druggist and he will tell her if a difference exists.



- Page 2126 Two last lines.----will tell him what she has, and he will likely order that drug

- Page 2130 Paragraph 2, line 3 -----a general rule under the Pharmacopoeial name, there are exceptions.
and line 12 ---- they all kept the quality up to the standards of ----
- Page 2130 On this page and elsewhere PETHIDINE is misspelled, PATHODINE.
- Page 2131 Paragraph 6, line 6-----know but I would say right now we buy a 30 cc vial for 40 cents a bottle less, that's \$40 a 100 vials.
- Page 2137 5th line from bottom of page-----Mr. Johnston: Not for small quantities that

- Page 2140 Paragraph 7, line 1: and following lines:
Mr. Johnston: We stock both ways. For instance, Demerol; if a strange night supervisor was on duty, and this is unusual, because we don't usually run out of ward supplies at night; if a strange night supervisor came along with an order for Demerol and looked up this index under Demerol, it would say Pethidine B.P. and Meperidine U.S.P., and if she checked the cards for Pethidine she would find Demerol-----
- Page 2142 Paragraph 4, line 6-----have found we can purchase some surgical equipment more-----
- Page 2145 Paragraph 6-----Mr. Bryden: Line 3-----"Chlorophenol" is shown. I believe that "Chlorpromazine" was referred to
- Page 2150 Paragraph 1, lines 5 and 6-----poured out, regarding many of the uses of the drugs. In my opinion, I feel that they are trying something, and keep----
- Paragraph 3, line 4-----pressure on doctors to operate, and the doctor----



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- Page 2151 Second line from bottom of page-----
 British Pharmacopoeia quality by putting
 the letters -----
- Page 2153 Starting at first line-----can tell fairly
 closely after looking at drugs for
 20 or 25 years, if it is off colour,
 or has an odd smell or is hydrolizing

- and eighth line from bottom of page----
 be placed on the manufacturer providing
 the doctor had-----
- Page 2154 Eighth line from top-----quality, first of
 all, then the price and the delivery
 date-----
- Page 2156 Fifth line from top-----Lederle's, and
 Achromycin, that is Lederle's too.
- Page 2157 Third line from top of page onwards-----
 used once a month and some three times
 a year, that's not a large volume, a
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- Page 2159 Last word on tenth line should be
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SELECT COMMITTEE ON DRUGS

Proceedings of hearings
held at Parliament Buildings,
Toronto, Ontario, on Tuesday,
the 13th of June, 1961,
at 2.25 p.m.

COMMITTEE:

MR. H.L. ROWNTREE, Q.C. -- Chairman

MR. A. WREN

MR. J.A. FULLERTON

MR. J. TROTTER

MR. R.E. SUTTON

MR. R.J. BOYER

MR. N. WHITNEY

MR. H.J. PRICE

MR. K. BRYDEN

MR. J. WHITE

MR. G.F. LAVERGNE

MR. S.J. GADSBY, F.C.I.S., Secretary

MR. HAROLD A. RICE -- Committee Counsel

MR. W.J. AYERS -- Accounting
Consultant to the
Committee



SELTAGE COMMITTEE ON BRICK

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Toronto, Ontario, on Tuesday,
the 13th of June, 1961,
at 2.30 p.m.

MR. H. L. BOWNIER, Q.C. -- Chairman

MR. J. A. ...

MR. J. ...

MR. ...

MR. R. J. BOWEN

MR. W. ...

MR. ...

MR. ...

MR. ...

MR. ...

MR. S. L. GADSBY, F.C.I.B., Secretary

MR. HAROLD A. RICE -- Committee Counsel

MR. W. J. AYERS -- Accounting Consultant to the



---On resuming at 2.25 p.m.

THE CHAIRMAN: Mr. Rice?

MR. RICE: Mr. Chairman and members of the jury.

THE CHAIRMAN: Members of the what?

MR. RICE: I am sorry, members of the Committee. This afternoon we have representatives from three hospitals and also the National Sanitorium Association.

First we would like to introduce to you Mr. Peter Breel, Administrator of the Alexandra Hospital, Ingersoll. For the purposes of the record, Mr. Breel, would you state your full name please?

MR. BREEL: Yes, Peter M. Breel.

MR. RICE: What is your occupation?

MR. BREEL: I am the Administrator of the Alexandra Hospital, Ingersoll.

MR. RICE: How long have you been Administrator of the hospital?

MR. BREEL: Since January of 1959.

MR. RICE: What did you do prior to that time?

MR. BREEL: I was purchasing agent at the General Hospital in Chatham.

MR. RICE: How long were you in that position?

MR. BREEL: Nearly three years.

MR. RICE: What did you do prior to that



---On resuming at 2.25 p.m.

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Mr. Bree, would you state your full name please?

MR. BREE: Yes, Peter M. Bree.

MR. RICE: What is your occupation?

MR. BREE: I am the Administrator of the

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MR. RICE: What did you do prior to that



position?

MR. BREEL: I was office manager in the Northern General Hospital in Norfolk.

MR. RICE: How long were you office manager of that hospital?

MR. BREEL: Three years.

MR. RICE: What position did you have prior to that?

MR. BREEL: I did accounting work, general accounting work in industry.

MR. RICE: How long were you at that?

MR. BREEL: Ever since I started working.

MR. RICE: How long in toto have you been associated with hospitals?

MR. BREEL: Since the beginning of 1953.

MR. RICE: I understand you to have representations to make to the Committee on behalf of the Alexandra Hospital, Ingersoll, of which you are now Administrator. Would you please proceed.

SUBMISSION OF

ALEXANDRA HOSPITAL, INGERSOLL, ONTARIO

APPEARANCE: Mr. Peter M. Breel, Administrator
Alexandra Hospital.

Mr. Chairman and members of the Committee,
enclosed please find a short brief dealing with procedures relating to the purchase, distribution, analysis, storage, inventory and accounting of drugs



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ALEXANDRA HOSPITAL, INGERSOLL, ONTARIOMr. Peter M. Bresel, Administrator
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Mr. Chairman and members of the Committee,

enclosed please find a short brief dealing with pro-
cedures relating to the purchase, distribution,
analysis, storage, inventory and accounting of drugs



and pharmaceutical preparations made use of in our hospital.

I trust that the information contained herein will serve a useful purpose.

Alexandra Hospital is a 56 bed, 14 bassinette, general hospital of the Class C. type. Admissions run about 1500 per year. Births run 250 a year, and patient days number about 16,000.

To serve the area, seven general practitioners form the active medical staff. The active staff is augmented by the consulting staff, made up by specialists from Woodstock and London.

One of our medical staff committees is the pharmaceutical committee. This group, together with the administrator and a pharmacist is designed to assist the administrator, set-up, control and make necessary changes to our formulary.

The Alexandra Hospital Trust is comprised of 14 members. The Trust delegates its responsibility and authority through the administrator to the 75 personnel of the hospital.

Presently we are completing an addition of 15 beds to serve the chronically ill in our area.

PURCHASE OF DRUGS

Addendum I of this report shows a sample page from our formulary. The formulary lists some 500 drugs that are stocked in the hospital. It is the responsibility of the Director of Nurses to



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is the responsibility of the Director of Nurses to



ensure that sufficient stock of the drugs listed on the formulary, is available at all times.

The formulary itself evolved through years of medication habits. In the beginning the formulary was no more than a supply of the most widely used drugs. Now, the formulary has become a formal entity. It is a list of drugs that are always in supply at the hospital. Copies of the formulary are on each nursing floor. Additions to, and deletions from the formulary, can be made only through the pharmaceutical committee.

There are two ways in which we purchase drugs. One is to keep our basic stock, that which is listed on the formulary, up to date, the other is where a prescription is filled outside the hospital for individual patients.

When a drug is purchased for our basic supply, there are several factors influencing the quantity to be purchased:

The expected quantity to be used in the next 6 months to 1 year;

The shelflife (expiration) of the drug;

The quantity discount available.

Where a quantity discount is available, it seems that the small hospital is penalized for its inability to purchase in quantity.

Should the physician order a drug not stocked by us, a supply is purchased sufficiently large to serve the patient's need while in hospital

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Should the physician order a drug not stocked by us, a supply is purchased sufficiently large to serve the patient's need while in hospital



only. The drug is almost always purchased at one of our three local drugstores. While we must pay a small premium for this, it is generally felt that this is still far less expensive than keeping a complete stock of drugs on hand.

DISTRIBUTION OF DRUGS

Addendum II of this report shows a list of drugs which are stocked on each nursing floor. This is commonly known as a wardstock.

The medication nurse uses this stock when filling the Doctor's order, and she is responsible to keep it replenished.

If the drug ordered by the Doctor for the patient's use is not available from "wardstock", the floor-nurse requisitions a supply sufficient for the patient's need from the drug room.

Should the drug be one that is not listed on the formulary, and of course not available from our stock, a supply of that drug is then ordered from a local druggist.

As the continued use of drugs when not necessary is not only expensive, but dangerous to the patient's health and health habits, our medical staff has imposed automatic stop-order on certain classes of drugs. A copy of the "standing order" is attached in Addendum III.

ANALYSIS OF DRUGS

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to assure ourselves of the quality of a drug. It is felt that by purchasing "trade name" drugs, rather than drugs by their "generic name", and by carefully watching expiry dates, a sufficiently effective quality control is being exercised.

Although our pharmaceutical committee has discussed the purchase and use of "generic name" drugs, nevertheless it was decided not to change our policy.

Some of the reasons for this decision are that trade names are often much better known than the generic name. Not only medical personnel, but also nursing personnel find the use of these purposely "catchy" trade names a great deal easier.

The reputation of the manufacturer too, plays a large role in helping the staff to determine to prescribe a drug or not.

It can be said that the products from the majority of manufacturers are of high quality. There are other companies that we have had no contact with. It is easy to see how anyone without the proper facilities to test quality, would hesitate to purchase a drug of unknown quality from a relatively unknown supplier - regardless of the price of the drug.

STORAGE

All of our bulk drugs are stored in what we call "the pharmacy", although we have not a chief pharmacist. They are stored in such a manner that all



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1765-

STANDARD

All of our bulk drugs are stored in what

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drugs affecting different parts of the body, or drugs having the same particular effect are stored together.

As well, an alphabetically arranged perpetual inventory card bearing the drug's name, is marked with the shelf number.

In this manner, a person knowing what type of drug he wants can find it in a group of similar drugs, or a person looking for a bottle of drugs by name, only has to refer to the file to find the shelf number and location of the drug.

Special precautions are taken to prevent pilferage. Also, a fire detecting system and automatic chemical extinguisher protect the hospital from the danger of fire from the more highly inflammable goods.

Narcotics, of course, are stored and accounted for according to law.



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Special precautions are taken to prevent pilferage. Also, a fire detecting system and automatic chemical extinguisher protect the hospital from the danger of fire from the more highly inflammable foods.

Narcotics, of course, are stored and accounted for according to law.



dpw

INVENTORY AND ACCOUNTING

The inventory is controlled by the perpetual inventory. Like all perpetual systems there is a card for each drug, on which is recorded the amount purchased, the supplier, each requisition filled, minimum and maximum supply and other pertinent data.

The perpetual inventory is helpful when ordering new supplies. It reminds the operator when stocks are getting low, and at the same time provides all the information necessary to order a new supply.

The physical stock is checked semi-annually against the stock as shown on the perpetual inventory.

The arrival of the drugs is certified by our receiver who sends his receiving slip to the office. The office staff match the receiving slip with the invoice, check it for quantity, cash discounts, additions and extensions as well as the known cost of this drug and pay the invoice.

The cost of pharmacy operation has been as follows:



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ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Breel

2073

	1957	1958	1959	1960
Patient days	13,152	12,812	14,642	15,710
Cost of Drugs	\$6,049.	\$6,789.	\$9,044.	\$10,094.
Drug cost per patient day	\$.46	\$.53	\$.61	\$.64
Cost of Salaries	\$825.	\$850.	\$875.	\$905.
Total Pharmacy Cost	\$6,874.	\$7,639.	\$9,919.	\$10,999.
Pharmacy Cost per Patient day	\$.52	\$.59	\$.67	\$.70



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

ADDENDUM I

Breel

2074

Sample from Formulary

DRUG	FORM	STRENGTH	SUPPLIER	SHELF
Achromycin V	Syrup		Lederle	A2
Achromycin	Inject	100 mg 250 mg	"	"
Achromycin V	Caps	250 mg	"	"
Achromycin	"	250 mg	"	"
Achromycin Surg.	Pulv	5 mg	"	"
Albamycin	Caps	250 mg	Upjohn	"
Aureomycin	Caps	50 mg 100 mg	Lederle	"
Aureomycin	Caps	250 mg	"	"
Azotrex	Caps		Bristol	"
Bionets	Tabs		Horner	"
Bicillin				
(all Purpose)	Inject		Wyeth	"
Neomycin				
(Mycostatin tabs)			Squibb	"
Mysteclin V	Tabs	250 mg	Squibb	"
Terramycin	Caps	100 mg 250 mg	Pfizer	"
Achromycin	Paed	drops	Lederle	AZ
Chloromycetin	Caps	50 mg 250 mg	Parke Davis	A3
Chloromycetin	Inject	1 gram	"	"
Chloromycetin			"	"
Palmitate			"	"
Erythrocin Lactobionate		1 Gram	Abbott	"
Forpen	Tabs	400,000 i.u.	Horner	"
Ilotycin	Tabs	250 mg	Lilly	"
Iantrex	Vials	1 gram	Bristol	"
Staphicillin	Inject		Bristol	"
Polybactrin	Spray		Calmic	
Crystamycin	Inject	0.5 gm	Glaxo	
Declomycin	Caps	150 mg		
Cozyme	Inject	250 mg	Travenol Abbott	A4
Penicillin G				
Sodium	Inject	500,00 u	Glaxo	"
Neutropen	Inject		Schering	"
Kryl	Loz enges		Ayerst	"
Hylenta Forte	Tabs	1,000,000 u	"	"
Hylenta	Tabs	500,000 u	"	"
Secrets			Sharpe & Dohme	"
Seclopen	Inject	4,000,000 u	Glaxo	"
Seclomycin	"		Glaxo	"
Stroptomycin	"	5 gm.	Merck	"
Varidase			Lederle	"
Cicatrín	Pulv		Calmic	A5
Cicatrín	Ung		"	"
Degenan	Tabs	gr 7½	Poulenc	"
Cremosuxidine	Liquid		Sharpe & Dohme	"
Sulfaquanadine	Tabs	gr 7½	Lederle	"
Sulfathiazole	Tabs	gr 7½	Can Pharm	"
Sulfadiazine	Duolets	gr 7½	Wampole	"
Sulfadine	Tab	0.5 gm	Ayerst	"
Sulfamerazine	Tab	5 gm	Sharpe & Dohme	"
Sulfasuxidene	Tab	5	"	"
Sulfanalone	Tab	gr 7½	Hartz	"

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ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

ADDENDUM II

Breel.

2075

Frosst #292	Amphojel S.A.
Frosst #282	Day Barb. $\frac{1}{2}$ gr.
Demerol 100 mgm per 2 cc.) Amp.	Stelabid $\frac{1}{2}$
Demerol 50 mgm per 1 cc.)	Seclomycin
Demerol 50 mgm tablet	Seclopin
Morphine grs. $\frac{1}{4}$	Cozyme
Morphine grs. $\frac{1}{6}$	Bicillin
Morphine grs. $\frac{1}{8}$	Bionets
Codeine grs. $\frac{1}{2}$ t.t.) hypo	Neomycin - Mycostatin
Codeine grs. $\frac{1}{2}$ t.t.)	Declomycin 150 mgm.
E.M.C. # 1	Premarin 20 mg.
T.O.A. grs. $\frac{1}{3}$	Stilboestrol 0.5 mg.
Nisentil 10 cc vials	" 1.0 mg.
Sod. Nembutal vials $\frac{3}{4}$ gr.	" 5 mg.
Amytal Sodium grs. 3	Sodium Salicylate grs. V
Amytal sodium grs. 1	Soda Bicarbonate Crs. X
Cerbrital cap.	Hematinic Plastules
Doriden Tab. 5 gm.	Potassium Chloride grs. V
Nembutal grs. $\frac{1}{2}$	Calcium Gluconate grs. X
Nembutal grs. $\frac{3}{4}$	Cevalin 100 mg. with Vit. C
Seconal grs. $\frac{1}{2}$	Restropin (plain)
Seconal grs. $\frac{3}{4}$	Mandalamine 0.5 gm.
Sodium Luminal	Mobenal
Tuinal 3.4 gr.	Desi Thyroid grs. $\frac{1}{2}$
Tuinal grs. 3	Bominal with C.
Digoxin 0.25 mg.	A.B. Dol with Vit. C.
Digitalis grs. 1	Bominal with B
Pyridium 0.1 gm.	Ferrous Sulphate grs. V
Purodigin 0.1 mg.	AzQ. Gantrisin
Atinophylline grs. $\frac{1}{2}$	Gantrisin $\frac{1}{2}$ gm.
Peritrate 10 mg.	Hydro Diuril 50 mg.
Neuratrastentin (Plain)	Diuril 500 mg.
Diamox 250 mgm	Uro Vesical grs. V
Serpasil 0.25 mg.	Urecholine 10 mg.
Pyrobenzamine 50 mg.	Tace
Triaminic	Aspirin grs. V
Chloromycetin 250 mg.	Aspirin grs. 1
Achromycin V 250 mg.	Nitroglycerin 1/200 gr.
Azotrex	Phenabarb grs. $\frac{1}{2}$
Sulfathiazole grs. $7\frac{1}{2}$	Atropine grs. 1/200
Sulfaquinoxaline $\frac{1}{2}$ gm.	Dilantin Sod. grs. $1\frac{1}{2}$
Sulphathalidine 0.5 gm.	Frosst #217
Tri sulfa grs. $7\frac{1}{2}$	Frosst #222
Albamycin T. 250 mg.	Nitroglycerine grs. 1/100
Pen-Vie Penicillin V 125 mg.	Phenobarbital grs. 1/155
Kylenta 5	" $\frac{1}{2}$
Madribon	" $\frac{1}{2}$
Forpen	Largactil 25 mg.
Asporgum	Sparine 25 mg.
Bominal -liquid	Sparine 50 mg.
Bowon Elixir	Fergon Ferrous Gluconate
Felbesyn	Het acortan 5 mg.
proluton	Cortone 25 mg.
Solu-Cortif 100 mg.	Hydro Cortone 20 mg.
Elixir Turpin hydrate with	Stelazine tablets 1 mg.
Codeine phosphate	Dicumaryl 100 mg.
Amphojel plain	Veg. Lax



ADDENDUM II (Page 2)

A.B.S. & C. Tablet

Rufus Compound

Dulcolax

Gravol 50 mg.

Gravol 75 mg.

Ephedrine grs. $\frac{1}{2}$

Tafronil

Danilane 50 mg.

Butazolidin 100 mg.

Benadryl 25 mg.

Puradantin tablets 50 mg.

Digifortis grs. 155

ADDENDUM III

Standing Order re Automatic Stop Order

Effective June 4, 1959, unless the attending Physician has left a signed order indicating the number of days medication is to be continued, the nurse shall, immediately after notifying the doctor, discontinue medications as indicated below:

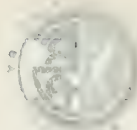
1. 40-hour automatic stop - on single narcotics
2. 72-hour automatic stop - on broad spectrum

On broad spectrum antibiotics

Short-acting barbiturates; and

corticosteroids.

ADMINISTRATOR



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MR. RICE: Can you tell us who sits on this pharmacy committee you have at your hospital?

MR. BREEL: Yes. It is our chief of staff, one of the general practitioners, and director of nursing.

MR. RICE: Is there a pharmacist on the committee?

MR. BREEL: According to our by-laws there should be, but in practice we don't call a pharmacist in on the committee. Although the Chairman of our Board is a pharmacist and is interested in this committee, he does not usually attend. We have yet to find anything that is important enough to call him on.

MR. RICE: How often does this committee meet?

MR. BREEL: According to the by-laws, they must meet monthly. In practice they probably meet every two or three months. Whenever the drugs need to be added to.

MR. RICE: When you purchase drugs, I note in your brief you have a certain amount of purchasing through retailers. Who else do you purchase from?

MR. BREEL: We prefer to deal with the manufacturer. Some drugs are not available through manufacturers.

MR. RICE: Do you have a system of calling for tenders for any of the drug firms?



MR. RICE: Can you tell us who sits on this pharmacy committee you have at your hospital?

MR. STELL: Yes. It is one chief of staff, one of the general practitioners, and director of nursing.

MR. RICE: Is there a pharmacist on the committee?

MR. STELL: According to our by-laws there should be, but in practice we don't call a pharmacist in on the committee. Although the Chairman of our Board is a pharmacist and is interested in this committee, he does not usually attend. We have yet to find anything that is important enough to call him on.

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MR. RICE: When you purchase drugs, I note in your list you have a certain amount of purchased through retailers. Who else do you purchase

MR. STELL: We prefer to deal with the manufacturer. Some drugs are not available through

MR. RICE: Do you have a system of calling for tenders for any of the drug firms?



MR. BREEL: No, we have not used the tender system. As you can see from our cost, the total cost involved is not very great.

MR. RICE: When you purchase from manufacturers, what discount do they give you?

MR. BREEL: We receive the standard discount. It varies from manufacturer to manufacturer. I believe the normal discount is 40%.

MR. RICE: When you buy from wholesalers, what discount do you receive from them?

MR. BREEL: Sometimes it is the same. Usually it is just a little bit less. It ranges between 30 and 40%.

THE CHAIRMAN: What is the difference between the price level from the wholesaler to the manufacturer?

MR. BREEL: In some cases the prices are the same. We can buy as low, pricewise, from the manufacturer as from the wholesaler. In other cases, the wholesaler's price is a shade higher.

MR. RICE: When you make these purchases from some of the retail manufacturers, do you get any discount there?

MR. BREEL: Yes, we receive presently 25% discount.

MR. RICE: That 25% discount, is that 25% off the manufacturer's list price, or 25% off the retailer's price?

MR. BREEL: 25% off the retailer's



MR. BREED: No, we have not used the

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total cost involved is not very great.

MR. RICE: When you purchase from manu-

facturers, what discount do they give you?

MR. BREED: We receive the standard

discount. It varies from manufacturer to manufacturer.

I believe the normal discount is 4%.

MR. RICE: When you buy from wholesalers,

what discount do you receive from them?

MR. BREED: Sometimes it is the same.

Usually it is just a little bit less. It ranges

between 3% and 4%.

THE CHAIRMAN: What is the difference

between the price level from the wholesaler to the

manufacturer?

MR. BREED: In some cases the prices

are the same. We can buy as low, price-wise, from

the manufacturer as from the wholesaler. In other

cases, the wholesaler's price is a shade higher.

MR. RICE: When you make these pur-

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get any discount there?

MR. BREED: Yes, we receive presently

2% discount.

MR. RICE: That 2% discount, is that

2% off the manufacturer's list price, or 2% off

the retailer's price?

MR. BREED: 2% off the retailer's



price.

MR. RICE: 25% less than he would sell it to the man on the street for?

MR. BREEL: Yes, that is correct.

MR. RICE: I take it from your brief you rely wholly on the reputation of the manufacturer? You have no method of analysing or you don't submit any of your drugs for analysis or anything along that line?

MR. BREEL: That is correct.

MR. RICE: Have you a pharmacist on the staff of your hospital?

MR. BREEL: We have not.

MR. RICE: Who is in charge of the pharmacy or the dispensary?

MR. BREEL: Our director of nursing is in charge.

MR. RICE: What qualifications has he or she?

MR. BREEL: She is a nurse. Other than that she has no qualifications.

MR. RICE: What would be the total value of your yearly turnover in drugs, Mr. Breel?

MR. BREEL: In 1960 we purchased just over \$10,000-worth of drugs.

MR. RICE: What would be the total expenditures of your hospital in 1960?

MR. BREEL: It was between \$250,000 and \$300,000.



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MR. RICE: What would be the total

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MR. BREWSTER: It was between \$250,000

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MR. RICE: Have you ever received any complaints about your drugs?

MR. BREEL: From?

MR. RICE: From the patient or doctor or anyone using them at all?

MR. BREEL: In regard to price?

MR. RICE: In any regard. Price, quality or any other way?

MR. BREEL: No.

MR. RICE: When prescriptions are needed who fills the prescription from your dispensary?

MR. BREEL: Our director or nurses or her delegate.

MR. RICE: Who is her delegate? Who would that be?

MR. BREEL: The delegate would be second in command of the nursing staff. Senior nurse.

MR. RICE: Would they have any training in pharmacy apart from their nurse's training?

MR. BREEL: No.

MR. BOYER: Does that involve compounded prescriptions?

MR. BREEL: We don't compound any prescriptions.

MR. RICE: All your prescriptions are pre-prepared drugs, are they?

MR. BREEL: That is correct.

MR. RICE: If you haven't a drug on



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MR. RICE: If you haven't a drug on



your formulary or in your dispensary as required, is there any prescription for substitution?

MR. BREEL: Yes. Often we call a physician and inform him that this drug is not on the formulary, and if he doesn't have any particular reason to use that particular drug and is willing to substitute it for one we have in the formulary, we are quite willing to do that.

MR. RICE: On these pre-prepared drugs, do you remove the label, the manufacturer's label on it before you distribute them to the patient?

MR. BREEL: No. Usually we purchase drugs in bulk which means we dispense it to the nursing floors, and we have to break the bottle and put smaller quantities for stocking other bottles.

MR. RICE: When they do come in the prescribed size, you don't have to take off the manufacturer's label?

MR. BREEL: No.

MR. RICE: Is there any method whereby patients can purchase drugs from your hospital?

MR. BREEL: No, we have no organized out-patients department, and we are not allowed to sell drugs.

MR. RICE: Your in-patients, do the drugs show as a separate part of their account?

MR. BREEL: No. Since January 1st, 1959, our rates are all-inclusive.



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C/PB/mt

MR. RICE: Does the Ontario Hospital Services Commission check your routine or your methods with regard to purchasing and supplying of drugs?

MR. BREEL: No, not so far. They are interested in the amount per patient day we spend on drugs. That is a budgetary control.

MR. RICE: I note from your brief that the cost per patient day appears to be increasing. Has the consumption of drugs also increased or can you give me any explanation why it would be increasing?

MR. BREEL: Yes, I think that is true, since January 1st, 1959 and the commencement of the Hospital Insurance Plan freer use has been made of drugs naturally. You will notice in 1960 it seems to be straightened out. This year we are at the same level as last year.

MR. RICE: Do any of the members of the Committee have any questions?

MR. BOYER: Is it the hospital practise to sell drugs only if it has an out-patient clinic?

MR. BREEL: We do sell drugs to patients that come in for emergency treatment, but we don't make a habit of selling drugs to persons who stop by in his car and says, I have a tummy ache, I want a Tum.

MR. BOYER: Somebody previously told the Committee hospitals are not allowed to sell drugs. We heard yesterday a gentleman from the

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Sick Childrens' Hospital in Toronto, a large hospital which has a sizeable out-patient's clinic and he said it was quite in the right of a hospital to sell drugs on prescription. There must a difference between the different classes of hospitals?

MR. BREEL: Right, if a hospital has an organized out-patient department it is convenient for the patient to be able to go to the drug store in the hospital and have his prescription filled.

MR. TROTTER: Mr. Breel, you think that smaller hospitals could buy drugs more cheaply if there was a central agency from which to buy the drug?

MR. BREEL: Yes, but it would depend on how much it would cost to run the central agency, but I know the small hospitals are penalized because we can't purchase in large quantities.

MR. TROTTER: Has your hospital made any attempt to form such an agency or central pool?

MR. BREEL: I have this year for the first time made arrangements to purchase a drug and split it between two other hospitals. This will save us 30 or 40% of the cost of the drug.

THE CHAIRMAN: 30 to 40%?

MR. BREEL: Yes.

MR. TROTTER: What is the name of the drug?

MR. BREEL: It is a drug used in radiological diagnosis.



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THE CHAIRMAN: 30 to 40%?

MR. TROTTER: What is the name of the

drug?

MR. BREEF: It is a drug used in



MR. TROTTER: A high priced drug?

MR. BREEL: Yes, it is about \$1.00 a shot.

THE CHAIRMAN: I suppose we actually get into the question of whether or not the effective result or the effective saving is a major matter or is it a substantial saving against the particular ailment or the particular patient?

MR. BREEL: I am sorry, I didn't follow you.

THE CHAIRMAN: In the broad picture would that saving, according to your plan or proposal, would that saving cut down the cost of drugs in the hospital across the board?

MR. BREEL: Yes sir.

THE CHAIRMAN: Or is it confined to one or two patients who might have a particular ailment or disease?

MR. BREEL: It would reduce the total cost of operating the hospital.

THE CHAIRMAN: Yes.

MR. BOYER: Your hospital and smaller hospitals, the quantity you buy is not large enough to save alone.

MR. BREEL: Yes.

MR. FULLERTON: When the shelflife has expired what do you do with the drug?

MR. BREEL: In most instances we can return them for other goods, but we do so at reduced

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MR. FULLERTON: What exceptions do you have?

MR. BREEL: I can't think of one.
Perhaps we do it with all the drugs.

MR. TROTTER: Who on your staff actually buys the drugs?

MR. BREEL: The requisition for the purchase of the drugs comes to me from the Director of Nurses or her delegate and after initialling this purchase order goes through to the source of supply. In principle I purchase the drugs.

MR. TROTTER: Do you have the men, the detail men from the drug firms call on you?

MR. BREEL: Yes, most of the representatives call on us, either the Director of Nursing or I see them if they have something to offer us. We find we don't use a great deal of drugs, and they know that we purchase whatever we need and unless they have a new item to show us they don't bother us very much.

MR. WREN: Has anybody in your community expressed an interest in purchasing drugs from the hospital rather than the local drug store?

MR. BREEL: Yes, they have, sir.

MR. WREN: Where did that come from, the Council?

MR. BREEL: No, it came from several individuals, people who through some ailment require long-term medication and must purchase drugs by the



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thousand.

MR. WREN: What happens in your community when you have a person suffering from, say, chronic arthritis that might require a special drug constantly and they are not -- not necessarily indigent, but not well off.

MR. BREEL: I am afraid the only person that could help this patient would be our welfare officer.

MR. WREN: I am thinking of the case where they would not qualify for welfare.

MR. BREEL: We haven't and I don't expect that we will become involved in this matter. It is a very interesting one.

MR. WHITE: Mr. Chairman, I have a few questions. Mr. Breel, you have a formulary, which I suppose could be called a brand name formulary as opposed to a generic formulary. Are any of the drugs shown in Addenda I and II, are any of those the generic name or are they all brand names?

MR. BREEL: All of these drugs are brand name drugs, sir.

MR. WHITE: Have you considered acquiring at least some of these drugs under the generic name, aspirin, being an easily understood example?

MR. BREEL: Yes, we purchase aspirin by its generic name. It is such a horrible name nobody ever uses it. The more complicated drugs we haven't purchased by their generic name. One of our doctors

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that could help this patient would be our welfare

MR. BREEL: I am afraid the only person

well off.

and they are not -- not necessarily indigent, but not

arthritis that might require a special drug constantly

when you have a person suffering from, say, chronic

MR. WREN: What happens in your community

thousand.



is extremely interested in this, but on the whole the staff hasn't found the time to discuss this fully and go into it and make a decision on it.

MR. WHITE: Is aspirin likely the only drug you buy under the generic name?

MR. BREEL: There may be some very simple drugs we may buy under the generic name.

MR. WHITE: You have told us you don't qualify for some quantity discounts but that you recently made an arrangement with two or three other consumers -- I suppose they are hospitals, in your area?

MR. BREEL: Yes.

MR. WHITE: Would you mind telling us which hospitals they are?

MR. BREEL: No, it is the Tillsonburg Hospital and the Woodstock Hospital.



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lpw MR. WHITE: Would you expect that this group will now buy other drugs jointly to take advantage of quantity discounts?

MR. BREEL: Yes, it may develop. We have no formal organization set up to do this but in the past where there may be a way through the pork so that we may well develop as we go along.

MR. WHITE: Have any definite plans been made or any concrete discussion been held to accomplish this?

MR. BREEL: On this one item, yes.

MR. WHITE: But looking to the future you have not really discussed the possibility of buying other drugs. You just think it might develop?

MR. BREEL: Yes.

MR. WREN: Has this ever come up before the Ontario Hospital Association?

MR. BREEL: I am sorry -?

MR. WREN: Has any suggestion ever been made before the Ontario Hospital Association convention to do bulk purchasing?

MR. BREEL: I can't answer for them but I don't believe so.

MR. WREN: None that you have attended?

MR. BREEL: None that I know of.

MR. WHITE: Now I notice that the cost of salaries has increased 6 cents per patient day. That is, the cost of the salaries of dispensing the drugs has increased 6 cents per patient day each year



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from 1957 to 1960 and I wondered if that 6 cents was just chosen somewhat arbitrarily to reflect a variation of the overall salaries or if this was computed accurately?

MR. BREEL: No, you are correct the first time. We estimate that the director of nursing or her delegate spends one-quarter of her time dispensing drugs.

MR. WHITE: You have mentioned that the Chairman of the Board is a pharmacist. Is he a local practising druggist in the town of Ingersoll?

MR. BREEL: Yes, he is.

MR. WHITE: Was he instrumental in getting this rather generous discount off the list price of drugs for your hospital?

MR. BREEL: No, he was not. This is standard.

MR. WHITE: It is standard in your locality?

MR. BREEL: Yes.

MR. WHITE: But was it standard in Simcoe when you were there?

MR. BREEL: Yes, it was.

MR. WHITE: Do you think it is true in all of the towns across the Province?

MR. BREEL: Yes, I think so.

MR. WHITE: You mentioned that you buy from wholesalers, although I notice the suppliers shown in the Addendum No. I are all manufacturers so

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should that be headed "Manufacturers" instead of
"Suppliers"?

MR. BREEL: Yes, I think so.

MR. WHITE: Do you buy from the Drug
Trading Company?

MR. BREEL: No, we do not.

MR. WHITE: Are you permitted to buy
from them?

MR. BREEL: Yes, we could purchase from
them.

MR. WHITE: Do you know what discount
they would give you?

MR. BREEL: Their discount list is
available. I haven't got it with me but it's very
close to that of National Drug and the other whole-
salers.

MR. WHITE: We were told it was 33.1/3%
to the drugstores. Do you think it would be the same
to your hospital?

MR. BREEL: Oh in some cases I imagine
we could do better.

MR. WHITE: Do you know if you would
be eligible for the co-operative rebate which they
make semi-annually to the drugstores?

MR. BREEL: Yes, we would be.

MR. WHITE: The Ontario average drug
cost is something over \$1 per patient day. I know
that at St. Joseph's Hospital in London, which is a
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patient day. I am wondering why your per patient day cost is so much lower than the average and so much lower than St. Joseph's which is so well-regarded?

MR. BREEL: Yes, of course our hospital is a class E hospital and probably doesn't handle the very seriously ill patients that St. Joseph's would on a general basis.

MR. WHITE: So the bigger the hospital the more drugs they are likely to use per patient day?

MR. BREEL: Yes, right.

THE CHAIRMAN: And the more serious ailments that the patients would suffer from would be directed to the larger hospital?

MR. BREEL: Yes, this is true.

MR. WHITE: Now my last question relates to a statement in your brief which reads: "A person looking for a bottle of drugs by name..." but I would judge by the subsequent remarks you have made that "a person" would mean only the Director of Nursing or her delegate?

MR. BREEL: Yes, that is true.

MR. WHITE: Thank you.

MR. WREN: Mr. Chairman, your section of analysis of drugs, in the third paragraph you say: "...also nursing personnel find the use of these purposely 'catchy' trade names a great deal easier". Do you feel as an administrator that these trade names are purposely catchy?



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say: "...also nursing personnel find the use of

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easier". Do you feel as an administrator that

these trade names are purposely selected?



MR. BREEL: Yes.

MR. WREN: They would be designed to, you would think, influence you to buy that particular brand?

MR. BREEL: Well that is a very small factor. I am sure it would be good merchandising to have a smooth-sounding easier trade name on their product.

MR. WREN: Repeated often enough.

MR. BREEL: Right.

MR. BRYDEN: You say that the reputation of the manufacturer plays a large role in helping the staff to determine to prescribe a drug or not. Therefore, I presume the reputation of the manufacturer plays a role in determining what you will stock in your hospital?

MR. BREEL: Yes, that is true.

MR. BRYDEN: How does the reputation of the manufacturer become established? Is this merely what the doctors tell you? How do you determine whether it is a reputable manufacturer?

MR. BREEL: I am not sure just how you determine whether they are reputable. They are honest to deal with and their drugs are used by our medical staff who have complete trust in them.

MR. WHITE: So if the manufacturer persuades a doctor on your medical staff that he is a reputable manufacturer then that would likely



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MR. WHITE: So if the manufacturer persuades a doctor on your medical staff that he is a reputable manufacturer then that would likely



have an effect that his products would be purchased in your hospital?

MR. BREEL: Yes, that is true.

MR. BRYDEN: Now if a new manufacturer wanted to get on your list, in effect then he would have to spend some time persuading the doctor. Is that the way he would do it?

MR. BREEL: Yes.

MR. BRYDEN: Or how he would establish a reputation?

MR. BREEL: Yes, that is correct.

MR. BRYDEN: When you say that you stock all trade names, there are of course drugs such as tetracycline, for example, which is put out by a number of different manufacturers under a number of different trade names all at the same price, I believe except for the competition from the generic houses. Now what would your policy be on that? Would you stock more than one of those brands?

MR. BREEL: Yes, we do.

MR. BRYDEN: Would you stock all of them?

MR. BREEL: No, certainly not. Only the most popular ones. When I say "popular" I don't really mean popular in the sense of the word. The doctor will prescribe a special drug for a certain disease and he may choose one of a range of these tetracycline; the one that is indicated



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for that disease.

MR. BRYDEN: Yes, but for example Lederle and Pfizer, and so on, they put out much the same thing, as I understand it. Would you carry both Lederle's product and Pfizer's and Upjohn?

MR. BREEL: Yes, we do.

MR. BRYDEN: All I assume for essentially the same treatment?

MR. BREEL: For similar treatment, yes.

MR. BRYDEN: Doesn't that tend to inflate the cost of your inventory?

MR. BREEL: Yes, it does.

MR. BRYDEN: I presume you have to depend on what the doctors tell you. You can't get them to agree that perhaps they could cut down on some of this duplication in the stock?

MR. BREEL: Yes, this is the true reason for the Pharmaceutical Committee to be in existence and they do work - they have eliminated several drugs from our formulary in the last year or so. In the case of the antibiotics - I am not a druggist - but I believe it is correct to state that they are not all the same. They are different in their working.

MR. BRYDEN: They are not all the same. There is a fabulous variation. Some of the variations certainly must be only slight?

MR. BREEL: Yes, that is true.

MR. PRICE: I have several questions.

MR. BRYDEN: Yes, but for example

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Could you tell us what percent of drugs you purchase from retail outlets?

MR. BREEL: Oh probably less than 15%.

MR. PRICE: And from your experience do doctors prefer to have the prescription filled as directed without substitution?

MR. BREEL: Yes, I should say so. In our case we do not substitute unless we have referred to the doctor.

MR. PRICE: What would the drug inventory shortage be over the past three years? When you take inventory do you ever have a shortage?

MR. BREEL: Oh yes, we do. At the end of 1959 we were over our special inventory, and in any event the difference, in our case I have never noticed a difference that made us investigate.

MR. RICE: Any further questions from the Members of the Committee?



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MR. PRICE: Any further questions from

The Members of the Committee?



E/AG/hm

THE CHAIRMAN: Mr. Breel, thank you very much for coming before the Committee and giving us the benefit of your experience. We have no further questions.

MR. RICE: Mr. Chairman and members of the Committee, we have next Mr. Stanley Johnston, from the Leamington District Memorial Hospital. For the purpose of the record, would you state your full name please?

MR. JOHNSTON: My name is Stanley James Johnston.

MR. RICE: What is your occupation?

MR. JOHNSTON: My occupation is Hospital Administrator.

MR. RICE: Of which hospital?

MR. JOHNSTON: Of the Leamington District Memorial Hospital.

MR. RICE: How long have you been administrator of that hospital?

MR. JOHNSTON: Of that hospital I have been an administrator since March 1958.

MR. RICE: How long have you been associated with that hospital?

MR. JOHNSTON: Since March 1958.

MR. RICE: What did you do prior to March 1958?

MR. JOHNSTON: For five years prior to March 1958 I was the business manager of the Essex County Sanatorium, located in Windsor.



THE CHAIRMAN: Mr. Breef, thank you

very much for coming before the Committee and giving

us the benefit of your experience. We have no

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MR. RICE: What was your position there?

MR. JOHNSTON: Business manager.

MR. RICE: What did you do prior to being business manager of that sanatorium?

MR. JOHNSTON: I was the associate business administrator of the Metropolitan General Hospital, Windsor, Ontario.

MR. RICE: How long were you business administrator there?

MR. JOHNSTON: Two years.

MR. RICE: And prior to that time?

MR. JOHNSTON: I was pharmacist at Metropolitan General Hospital.

MR. RICE: How long?

MR. JOHNSTON: One year.

MR. JOHNSTON: And prior to that?

MR. JOHNSTON: In retail in Windsor for approximately a year before going to work in Metropolitan Hospital where they were looking for a pharmacist with hospital experience. Prior to being in retail, I was in England, and prior to that in the Air Force, and prior to that a pharmacist in St. Bartholomew's, London, England.

MR. RICE: Would you proceed then to deliver your brief for the Leamington District Memorial Hospital?

SUBMISSION OF

LEAMINGTON DISTRICT MEMORIAL HOSPITAL
Leamington, Ontario

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APPEARANCE: S. J. Johnston, Administrator,
Leamington District Memorial Hospital

Leamington District Memorial Hospital is situated in the town of Leamington, in Essex County about thirty miles south east of Windsor and forty miles south west of Chatham, Kent County. The nearest hospitals to us are in these cities.

The District Memorial Hospital in Leamington is the only Public General Hospital in the County of Essex outside the city of Windsor. It is well placed, being approximately halfway between Windsor and Chatham, to fulfill the needs of a large area of Southern Essex and part of West Kent.

The extent of the needs in this district is demonstrated by the fact that although the expansion program, which not only doubled the size and number of service departments but increased beds from 51 to 91, was officially opened by Dr. Matthew B. Dymond, the Provincial Minister of Health, only last June, all areas are already being used to capacity.

I mention the foregoing because although our expansion was relatively extensive, we are still classified as a Group "C" hospital, that is a hospital with fewer than 100 rated active treatment beds. With 91 active beds we are just under the upper limit for Group "C" and in my opinion the Leamington District Memorial Hospital is a good example of the pattern that will



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evolve in the years ahead, where the existing Group 'C' hospitals will be enlarging to meet the demands of our expanding population.

Group 'C' hospitals present special problems in organization and management not apparent in larger institutions. These problems largely arise from the fact that the volume of work involved is not always sufficient to justify, in the establishment, a full time professionally or otherwise qualified person to head every department. The span of control is much greater, one person being responsible for several functions, and hence the tight control and supervision of details achieved in a large hospital with full time department heads is not always possible.

This is particularly evident in consideration of the terms of reference which are "procedures relating to the purchase, distribution, analysis, storage, inventory and accounting thereof for drugs and pharmaceutical preparations made use of in (your) hospital". I will take them in that order.

PURCHASE:

Drugs and pharmaceutical preparations in this hospital might be conveniently divided into two main groups. Firstly - those medications which are used for patients only upon a doctor's order or prescription. This group includes such items as medications intended for use orally in tablets, syrups, etc; hypodermically, intravenously or



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intramuscular injection; externally to the skin, scalp etc; and all anaesthetics, gaseous or otherwise. These comprise in value about 95% of the drugs and pharmaceuticals used in our hospital. The majority of them are in the category of "Brand Name" drugs, and many are obtainable only under the registered Brand Name from a single manufacturer.

Due to the multiplicity of items the volume of individual purchases is low; there is thus little opportunity for quantity purchasing at discount, with this exception; that drugs and chemicals included in the British Pharmacopoeia, British Pharmaceutical Codex and the U.S. Pharmacopoeia must meet the standards of strength, purity, sterility, etc., laid down therein. In the case of these latter drugs guaranteed to meet the standards, by reputable manufacturers, competition prevails, and we derive some benefits in lower prices by "shopping around".

Secondly - Those drugs and pharmaceutical preparations used as sterilizing solutions for instruments; disinfectants and antiseptics, and massaging lotions and so on. It is the hospital's responsibility to maintain cleanliness generally, provide necessary nursing care, sterilization of equipment, and asepsis in the operating theatres, delivery rooms and nurseries and this being carried out to the satisfaction of the Medical Staff we do not have requests for special brands of the

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materials used for these purposes. Hence in this area we are free to select and purchase on the basis of quality, effectiveness for the purpose intended, and competitive price.

THE CHAIRMAN: Excuse me interrupting Mr. Johnston, but would you define the word asepsis?

MR. JOHNSTON: Asepsis means without infection, without the possibility shall we say without dirt, without germs.

I could develop it a little bit further. You may recall the old days when doctors operated in frock coats, with blood all over their gowns. This was before Pasteur, and then Lister brought in antiseptics such as carbolic, and then we had asepsis. In other words, everything used in the theatre is sterilized, and as much as possible we have an atmosphere in the theatre as free as is possible from germs, rather than have a spray to kill the germs we try to eliminate them.

THE CHAIRMAN: It has to do with cleanliness?

MR. JOHNSTON: It is fundamentally to do with cleanliness, and not only cleanliness, but also the killing of bacteria and spores which may be on apparently clean objects, by sterilizing them.

As will be inferred from the foregoing, the items in this second group represent only about



materials used for these purposes. Hence in this area we are free to select and purchase on the basis of quality, effectiveness for the purpose intended, and competitive price.

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five per cent of our total expenditure for drugs and pharmaceuticals.

The bulk of purchasing therefore is at the dictate of the Medical Staff of the Hospital. The only medicines purchased for the treatment of patients are those that are ordered by the doctors. Nothing is purchased on the chance that it might be called for.

At this hospital we have no person with the title of Purchasing Agent. The purchasing of all hospital supplies and services is done by the administrator in addition to his other duties.

Drug supplies are obtained from three sources.

- (a) Direct from the Manufacturer
- (b) From wholesale houses or distributors
- (c) From local retail Pharmacies,

as follows:

- (a) We purchase direct when any advantages accrue, namely, discounts for quantity, lower prices on competitive items, and for speed in delivery when the item is urgently needed.
- (b) The wholesale house provides a convenient source of supply for many items ordered in small quantities, one or two of a kind.

In purchasing as outlined in (a) and (b) above, the hospital receives a rebate of



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In purchasing as outlined in (a) and

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Federal Sales Tax averaging 9% or 10%, in addition to the discounts which vary from about 30% to 40% off the manufacturer's catalogue or list price.

Occasionally special prices to hospitals prevail.

(c) Purchases from local retail Pharmacies arise from necessity. This will be discussed in greater detail under the reference of "inventory" but for the present suffice to say that our arrangement with local stores is this: If we purchase a complete original package the local druggist discounts the price to the hospital by 25%. If we purchase a part bottle, that is, if the druggist has to open a bottle of, say, 100 pills and sells the hospital 25 and takes the very real risk of not being able to dispose of the remaining 75 pills, then he charges us for the 25 at the list price. We consider this to be a fair arrangement for the hospital. It is not practicable for us to claim rebate of Sales Tax on these locally purchased items which amount in aggregate to about \$25 to \$30 monthly, out of average monthly drug purchases of approximately \$1,950.00.

DISTRIBUTION:

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To demonstrate the evolution of a drug distribution service in a Group 'C' hospital I would like to explain that prior to our recent expansion program, when we were a relatively small hospital (51 beds), our drug supplies were stored in a very small room and were distributed as needed to the nursing units by the Director of Nursing or her deputy. This room was locked and inaccessible without the permission of the Director who kept the key. Any prescriptions that required extemporaneous compounding were ordered locally. In that size of hospital there was insufficient work of the nature that would justify the employment of a Pharmacist.

With the expansion of hospital services we found that not only because of increased demands on the "drug room", which had now graduated to a "Pharmacy" in new larger quarters, but also because increased responsibilities to be shouldered by the Director of Nursing precluded her from spending as much time as formerly issuing drugs, that we could now justify the services of a Pharmacist on a part time basis. The Pharmacist is paid \$3.00 per hour to attend three mornings per week (about 12 to 15 hours weekly). Nursing units replenish stock items and have new and repeat doctors' orders filled at these times.

The Pharmacy naturally is kept locked in the Pharmacist's absence. The Director of Nursing has access to obtain the odd item that is



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ordered during these times.

All items are ordered from Pharmacy on a requisition signed by the Ward or Unit Supervisor and must be countersigned by the Director of Nursing. This permits the Director an opportunity to scrutinize the quantities of drugs being used by each unit and to question any apparent misuse or abuse. The Pharmacist will expect an explanation from the Director of any abnormal requisition that she has approved. All medicines that are not regular ward stock (which is relatively inexpensive) are dispensed in individual containers for each separate patient. The requisition must show the patient's name, room number, name and strength of drug, the frequency and size of dose (this determines the quantity to be issued) and the Doctor ordering the same. Normally only two or three days supply is issued at a time. Nurses are not permitted to send any drug supplies home with patients on discharge. Any unused or discontinued drugs are returned to the Pharmacy where after inspection they are returned to stock or discarded.

The distribution of Narcotic drugs is subject to the controls laid down by the Federal Authorities and is regularly checked by the R.C.M.P. and Federal Inspectors.

ANALYSIS:

We have no facilities or personnel sufficiently trained to perform chemical analysis



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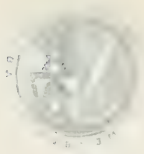


on drugs purchased. It is possible however for a Pharmacist, from accumulated knowledge and experience in handling many types of drugs and chemicals over the years, to detect abnormal colour or appearance, unusual odours and other physical characteristics which would preclude the use of the drug in question and indicate its return. It is also not too difficult to carry out a quantitative test of the average weight of a single tablet when it can be seen the tablets are identical and perfectly formed. Without a chemical analysis however it is impossible to determine the amount of active drug and the amount of excipient (or filler) in the tablet.

With the exception of the Provincial Laboratories of the Department of Health, I understand there are few analytical laboratories in the Province. These are operated for profit and routine use of these services by us would probably prove costly.

The Provincial Laboratories appear to be already burdened with work of a different nature, e.g., Public Health, V.D. and T.B. control, Biochemical Analysis, Clinical Pathology, etc.

I would venture the opinion that the establishment of the office of "Public Analysis" - there is a misprint. It should be Analyst. (Along the lines of the United Kingdom service) in each area served by a Provincial Laboratory would render an invaluable service in checking on the quality,



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and accuracy of Labelling, of drugs and chemicals sold as medicines for human use. An alternative, as I see it, would be a central analytical laboratory under the control of the Department of Health, to which manufacturers would submit samples of each batch of tablets etc., for a certificate of approval. A photostat of this certificate could be supplied to the purchaser by the manufacturer with each portion of the relevant batch sold, thus removing doubt as to the potency or purity of the articles under consideration and ensuring to the purchaser that competitive bids were made on identical specifications.

STORAGE:

Since storage is the starting point for distribution this aspect has been touched on previously under that heading. As already mentioned, all drugs and medicines before issue are stored in the Pharmacy which is locked when not in use. At each nursing unit there is a drug cupboard accessible only to Registered Nurses by permission of the Head Nurse. All dangerous drugs, and narcotics, are kept locked up and keys are in charge of the head nurse.

In addition to the above we have bulk storage for explosive and inflammable materials such as ether and anaesthetic gases which are placed in separate vaults adjoining the main stores in the basement. Each of these areas is separately vented to outside by fans with explosion proof motors to



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prevent accumulation or concentration of explosive gases from any containers that might inadvertently leak.

To summarize, drugs are controlled under locked storage from the time of receipt to the time they arrive at the point of use, and issued from stores only by authorized personnel on signed requisition.

INVENTORY:

This subject is difficult for me to divorce from Purchasing and Storage as it modifies the former and could create a problem in the latter. It has been estimated that approximately 400 so-called "new" drug products are introduced every year. Many of these items are tried by the medical profession once or twice and then for various reasons are discarded. This creates a continuing obsolescence of drug stocks. Every pharmacy, hospital or retail, has dozens of items in stock which will rarely, if ever, be called for again. The retail Pharmacist takes into consideration in setting his price the value of all these unsold part-bottles that will eventually find a place in the garbage can. The hospital cannot recover any part of this cost. Once a bottle has been unsealed it cannot be returned to the manufacturer for credit. This means that as far as the hospital is concerned, whether the patient takes 5 or 25 tablets, it costs the price of 100 if the balance is unused.

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Our biggest problem with inventory is to hold it to reasonable levels and reduce obsolescence by selective purchasing. This is a daily and time-consuming chore and is carried on in consultation with individual members of the Medical Staff.

Despite our best efforts the avalanche of "new" products gains on us month by month and when a complete physical inventory is taken at year's end we find a growing accumulation of obsolescent or dead stock.

It would be impossible to stock all new drugs as issued, even if it were not quite impracticable. In the first place we haven't the money and secondly we would have no room to store them.

Since we put no new drug into inventory until it has been ordered by a doctor, it necessarily follows that the first time it is asked for it must be purchased retail locally, since the nearest wholesale depot is at London (about 110 miles). We attempt to purchase the smallest quantity that will suffice for the patient's anticipated stay in hospital. If demand for this particular item continues and it appears to prove a useful drug with definite advantages over existing similar drugs we will then purchase a small supply from manufacturer or wholesaler. Stocks will be maintained as long as demand continues.

Each item in the Pharmacy is catalogued and cross-referenced as to its official or generic



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names and other trade names. When several manufacturers distribute the identical drug under different trade names, we keep only one brand in stock to be supplied against orders for that drug, the attending doctor permitting.

A greater problem in controlling inventory is the combination of two or more drugs in one preparation. We already may have the drugs in stock separately and one tablet of each would have the same effect but the combination tablet is frequently insisted on.

Where several manufacturers distribute the identical drug under different trade names, one will add a small quantity of another medication to the main ingredient. Very often, the addition appears of little value pharmacologically and sometimes may seem to be contraindicated, but it makes the preparation different, and thus it becomes an addition to the inventory. The other manufacturers, in defence, then bring out combinations to compete. This has been the case with vitamin and mineral preparations, steroids, antihistamines and the enormous flood of "tranquillizers" and ataractics, to name a few types.

Another form of duplication is the presentation of the same drug in different dosage forms, e.g., there is the single delayed action pill in the morning to take the place of the usual ones the patient might forget to "take three times



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a day after meals".

It is these different dosage forms and combinations of drugs that account for the bulk of obsolescent or disused preparations and costly inflation of inventory in our hospital.

ACCOUNTING:

This is a fairly simple book-keeping procedure performed as specified in the Canadian Hospital Accounting Manual. Uniform accounting methods are essential in making national statistics comparable. Since the inauguration of the O.H.S.C. Plan for Hospital Care, the cost of all necessary drugs is included in the per diem rate set by the Commission and we make no separate charge to patients. We set a budget for drugs (as well as all other supplies) which must be approved by the Commission and is used by them in establishing this rate. The Commission receives from us a monthly accounting of all purchases, year to date, and will question any abnormal expense.

We maintain for our own control purposes expense accounts for special types of drugs used in service departments such as X-Ray, Laboratory and Operating Theatres, in addition to the Pharmacy Account. The accumulated totals of monthly expense accounts is adjusted for increase or decrease of inventory at year's end in accordance with normal accounting practice.

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this presentation to yourself and members, and will be glad to answer any questions you may have, to the best of my ability.

THE CHAIRMAN: Mr. Johnston, do you mind me telling you I think this is one of the best briefs I have ever seen.

MR. JOHNSTON: Thank you.

THE CHAIRMAN: A very forthright statement, and I compliment you on it. Gentlemen?

MR. RICE: You have cut down my work considerably. Do you have pharmacy committees attached to your hospital?

MR. JOHNSTON: Yes. There was a pharmacy committee stipulated under the medical staff by-laws of the hospital, and when I went there it wasn't doing anything, but we did get it activated last year.

MR. RICE: Who sits on the committee?

MR. JOHNSTON: We have two members of the medical staff on the committee. We have the chief of the department of general practice, and vice-president of the medical staff. Now, these are just ex officio members. They are just two doctors that happen to hold that position at the time. The pharmacy committee consists of two doctors and myself.

MR. RICE: How often do they meet?

MR. JOHNSTON: On the average I would say about once a month.



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MR. RICE: In your purchasing, are there any drugs you can purchase by tender, or are all your requirements so small ---

MR. JOHNSTON: No, it would not justify buying by tender. We do purchase by quotation. We ask for a price on certain quantities, if you call that tendering, but my interpretation of tendering - we might perhaps ask for prices.

MR. RICE: You do shop around?

MR. JOHNSTON: We do shop around, yes. We check with the salesmen when they come around. For any tablet, we check the different catalogues of the manufacturers, and we find that they will sometimes shade the price in the catalogue if we write and ask them for a quotation.

MR. RICE: What is your yearly turnover of drugs last year?

MR. JOHNSTON: I don't have the figures with me. Speaking from memory, \$16,000 or \$17,000.

MR. RICE: What would be the total expenditures of your hospital last year?

MR. JOHNSTON: About \$450,000 in round figures.

MR. RICE: You mentioned in your brief that some drugs are discarded. Could you tell us what the total value of the drugs you have to discard, what the wastage would be in regard to drugs?

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that the drugs are used once or twice by doctors and discarded. They are discarded by them. They stop using them. They are not discarded by us. We only buy enough to fill one order. Do you understand? Do I make my point clear?

MR. WHITE: You made a number of references to obsolescence, and I gathered you did have to throw some away?

MR. JOHNSTON: Yes. That was in a different part of the brief. There are some drugs becoming obsolescent every day, as you can well realise, with 400 products coming on the market every year. Planned obsolescence - is that the expression? - they have a drug and they will sell the straight drug. I can't think of any specific example. Will we say a drug like an alkaloid, Reserpine - I am not a doctor. I can't speak medically. They get this thing going for a little while, and then it looks like many manufacturers are splitting the business, and they add another thing to it.

MR. BRYDEN: Your competitor may add something to it?

MR. JOHNSTON: To get the jump on them.

MR. WHITE: Mr. Rice is trying to determine the cost of throwing away or putting to one side the obsolescent drug.

MR. JOHNSTON: I couldn't give you a figure, Mr. Rice, but I can assure you by watching it day by day, we keep it very well figured. Even



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by closely watching it, I would take a guess, probably \$200 or \$300 a year.

THE CHAIRMAN: In your hospital?

MR. JOHNSTON: Oh, yes, just a small hospital.

THE CHAIRMAN: I suppose this planned obsolescence to which you refer is like the automobile business?

MR. JOHNSTON: That is what it amounts to.

MR. SUTTON: Would you recommend the Ontario Hospital Services Commission buy all of the drugs in the largest possible quantities, the largest possible discounts for all of the Ontario hospitals and take over all this obsolescence that you speak of?

MR. JOHNSTON: Well, sir, I don't think the Ontario Hospital Services Commission could do it.

MR. SUTTON: You think not? What about the analyses? You say you have not facilities or personnel sufficiently trained to perform chemical analyses on the drugs purchased. Do you feel the need of an independent check-up on these drugs you use?



by closely watching it, I would take a guess, probably \$200 or \$300 a year.

THE CHAIRMAN: In your hospital?
MR. JOHNSTON: Oh, yes, just a small

THE CHAIRMAN: I suppose this is an obsolescence to which you refer as like the auto-

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G/PB/hm

MR. JOHNSTON: I think that would be very valuable.

MR. SUTTON: Do you think the Ontario Hospital Services Commission could perform that function for all the hospitals in Ontario?

MR. JOHNSTON: It would be very good if they did. Whether that would be within their terms of reference I can't say. I think it is more along the lines of the control to the Department of Health.

MR. WREN: I liked your suggestion that the area provincial laboratories might undertake that work by appointing a public analyst.

MR. JOHNSTON: My contention is if there were such a person as a public analyst he wouldn't only analyze on request from the hospital but he would select at random samples that are being supplied and check with the printed label, that the contents printed on the label complies with what is actually in the bottle.

MR. BRYDEN: The Food and Drug Directorate do that to some extent?

MR. JOHNSTON: To some extent, I don't know how it works.

MR. BRYDEN: They do it only on the sample basis and a hospital usually wants to be sure that the particular product it has got is up to standard.

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Food and Drug people are responsible for checking samples on importation.

MR. BRYDEN: They also, I believe, they are also responsible for checking on purity as far as any of the drugs put on the market are concerned.

MR. JOHNSTON: It might well be. Apparently they haven't got the staff

MR. BRYDEN: They can only do it on an at random basis.

MR. WREN: These provincial laboratories do very good work. They have bacteriologists -- I have had some very skilled help. I have been very impressed with their work. I think this idea might have possibilities with several zones established in the province that might have public analysts.

MR. JOHNSTON: I think they should be under the Public Auditor, a man above reproach, so to speak. I know we may get private samples from private laboratories. We don't know -- you should be able to rely on the private laboratories but I think when it is private.....

MR. WREN: You could make spot checks.

MR. JOHNSTON: There is the possibility some manufacturer may be controlling a laboratory and may colour the reports. It may be a wild statement to make.

THE CHAIRMAN: What you are advancing is the idea of a certificate of quality?

MR. JOHNSTON: An independent one.



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MR. BRYDEN: You are in the position now, I take it, where you can't be absolutely sure about any of the products you get? You have no independent verifications of their qualities. You have to rely on previous experiences purely, would that be correct?

MR. JOHNSTON: That applies to every product we buy even some so-called ethical or reputable manufacturers. We have only their names.

MR. BRYDEN: You just have to do the best you can. You have no absolute criterion.

MR. JOHNSTON: That is right.

MR. BRYDEN: Of quality anywhere?

MR. JOHNSTON: That is right. We do have a safeguard so far as the drugs under official names, B.P. for the British Pharmacopoeia or the U.S.P. in the United States or the B.P.C. When that is on the label it insures that those drugs come to this standard and these standards are made very high. Unless we analyzed -- unless we were suspicious we would accept the label with the B.P. and B.P.C. and U.S.P. on it. If we ordered them as such and they had the label, that is a safeguard.

MR. WREN: Most of our Indian mocassins are made in Japan so the label doesn't mean too much.

MR. FULLERTON: Mr. Johnston would it be practical to establish a committee in the main area where you have possibly half a dozen hospitals and buy on a co-operative basis, drugs on a co-operative basis?



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MR. JOHNSTON: I think that would be a good idea for the items you are using in quantity, for instance you could buy your anaesthetic ether and we mentioned aspirin, that is the, that is acetylsalicylic acid, and other items of that nature that you buy in quantity, no doubt you could get the price. I know when I buy five thousand or ten thousand the price goes down, but the problem is when these new products keep coming out every day these groups would be too unwieldy because there is the delay, getting the group together and deciding which drug they are going to buy before the order is placed and they would have to be distributed from some central depot. It is too unwieldy for the majority of the items we are using. It is a good idea for the other items.

MR. FULLERTON: Staple drugs?

MR. JOHNSTON: That is right, there is quite a number of drugs you could.

MR. BRYDEN: Are there actually very many instances where these new products, so-called, are so important that they must be available instantly?

MR. JOHNSTON: In the opinion of the Medical Staff, yes.

MR. BRYDEN: I notice you said many of these items are tried by the medical profession once or twice and then for various reasons are discarded. I would presume the reasons would include such factors as the fact that they didn't



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include such factors as the fact that they didn't



produce the results that were claimed for them or perhaps even produced harmful results in some cases. What is happening is that the patients are getting things to test these products which haven't been properly tested before they went on the market.

MR. JOHNSTON: I would agree with that 100%.

MR. BRYDEN: So actually if there was a little slowing down of some of this new stuff it might be beneficial to the patients as well as economically.

MR. JOHNSTON: Yes, I would say possibly as a rough guess, possibly half of the drugs we use are the old and tried reliable drugs, bella donna, digitalis and so on, and the extract from these drugs, but we do have a turnover of the basic medicinal drugs. There is a steady turnover all the time. It is this other 50% we cannot project, don't know what we are going to use. I could give you an example we had yesterday. A doctor ordered six tablets for this patient who was to be operated on this morning, he wanted six tablets. . . . The pharmacist at the time phoned all of the drug stores and one of the drug stores out of the four in town had a bottle of 50, which he was loathe to open because once he opened the bottle he couldn't return it. He wanted to sell us 50. I said, I don't want to buy 50 and throw 44 away. How much are they? They were \$6.50 for the 50 tablets. \$6.50 comes a bit high for six



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tablets. We called the doctor back and asked if there is anything he might use. We mentioned one or two we happened to have which were reputed to have similar action. This was a new one on the market. The doctor said I have a sample in my office. I can have it sent down to you if you send a taxi to get it.

MR. BRYDEN: A detail man had been in to see him shortly before, no doubt?

MR. JOHNSTON: No, doubt.

THE CHAIRMAN: Had he? Had he?

MR. BRYDEN: I am putting this forward as an explanation of what happened. It wouldn't be fair for me to impose my comment on the witness.

THE CHAIRMAN: Do you know that the detail man did?

MR. BRYDEN: I said no doubt he did.

MR. JOHNSTON: I would say, Mr. Chairman, no doubt the detail man had been in or he had received a package in the mail.

THE CHAIRMAN: Are you in the position to say whether the detail man's representations were valid or invalid?

MR. JOHNSTON: I am not in a position to say that. I don't know. I don't know the product. I couldn't say.

THE CHAIRMAN: I think we have to be very careful of what is said in evidence here. I made some notes earlier, Mr. Johnston, on a total budget of \$450,000.00 and the drug or prescription drug factor was \$17,000.00 per year in your hospital. Would that be right?

MR. JOHNSTON: I am basing that on approximately 20,000 patient days at eight cents a day.



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approximately 20,000 patient days at eight cents a day.



THE CHAIRMAN: When we are talking about the inefficiency of prescribing drugs and the wastage, what degree does that constitute in relation to these figures?

MR. JOHNSTON: The actual amount of articles we wasted?

THE CHAIRMAN: Wastage and inefficient prescribing?

MR. JOHNSTON: I can't talk about inefficient prescribing because I am not theoretically in a position to say whether it is prescribed inefficiently. Are you referring to the professional competence?

THE CHAIRMAN: I am trying to get at the dollar value of the wastage.

MR. JOHNSTON: Well, sir, as I said it is a daily chore. We hold it down. It could be appreciable. We have held it down to a few hundred dollars a year by the simple token, or the simple means of purchasing only as much of this article as will last the anticipated stay of a patient in the hospital.

THE CHAIRMAN: Mr. Johnston, when you say a few hundred dollars do you mean \$200.00, \$300.00, \$400.00, \$500.00?

MR. JOHNSTON: As near as I could judge between \$200.00 and \$300.00.

THE CHAIRMAN: \$200.00 to \$300.00 a year against \$17,000.00 total prescription drug outlay.



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MR. JOHNSTON: They are not all prescription. That includes all our drugs, all the drugs and chemicals used in the department.

MR. RICE: Are there any prescriptions sold, Mr. Johnston, either to in-patients or out-patients?

MR. JOHNSTON: No.

MR. WREN: Would it be the practise in your hospital to substitute without the doctor's consent?

MR. JOHNSTON: Where the brand only is the difference, but where the actual chemical constitution of the drug is identical the doctors agreed that we could do it.

MR. WREN: Who make that decision if you don't have a full-time pharmacist?

MR. JOHNSTON: The doctors have agreed to this. The medical staff agreed and they have a motion on the books they will accept an identical product under another brand name.

MR. WREN: And actually who makes that decision if a substitute is necessary, whether the drug is the same composition or not?

MR. JOHNSTON: Who makes the decision if they are the same composition?

MR. WREN: Yes.

MR. JOHNSTON: Well, I will if I am there and the pharmacist, if she is there.

MR. WHITE: What about the cross-reference?



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MR. WHEN: What about the

reference?



MR. JOHNSTON: That is what I was coming to. In the absence of both of us the cross-reference tells because we have it under the official name, the generic name - which is sometimes the same but not always, and the brand name. In the case there is any doubt whatsoever she calls the doctor and tells him what she has and if she can't get him she calls a local druggist and he will tell her.

MR. WREN: In each case it is the pharmacist you are talking about?

MR. JOHNSTON: The pharmacist is the prime person.

MR. WREN: Would it ever be the nurse who makes that decision?

MR. JOHNSTON: No.

MR. WREN: She would never make the decision?

MR. JOHNSTON: No, she sends her order to the pharmacist and it is filled.

THE CHAIRMAN: Mr. Johnston, isn't it a fact in certain hospitals that there is a formulary which exists which has a list of substitutes which it has determined by the medical staff of the hospital?

MR. JOHNSTON: Yes, that is right, many hospital formularies have a list of drugs.

THE CHAIRMAN: So if Doctor A came in and ordered a certain prescription or drug and it wasn't available the pharmacist would then check the formulary as laid down by the Committee, and if there was



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THE CHAIRMAN: So if Doctor A came in

and ordered a certain prescription or drug and if

wasn't available the pharmacist would then check the

formulary as laid down by the Committee, and if there was



an equal substitute, approved by the Committee, he could then substitute against that?

MR. JOHNSTON: That is right. When I was at the Metropolitan Hospital in 1950 and 1951 we had such a list.

MR. WREN: Is it not the policy or practise in some hospitals, the larger ones particularly, that the Doctor gives a substitute on his prescription if one becomes necessary?

MR. JOHNSTON: Yes, some doctors may do that. This formulary -- it is different, it serves a different function in that in the past it was a collection of recipes of medicines that were actually compounded in the dispensary of the hospital. Today it is more a work of reference. A doctor wants to order a certain drug and he will look up in this formulary -- he will look under the brand name and opposite that see listed the brand name and generic name or official names. He will generally ask which one they have in stock and she will tell him she has or hasn't and tell him what she has, and he will likely order that drug.



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THE CHAIRMAN: But if the alternate item is not in the formulary approved by the medical staff does anyone in your hospital have any authority, a nurse, to make a substitution?

MR. JOHNSTON: No sir. No nurse is allowed to substitute on her own volition. She must go right to the doctor and get his permission.

MR. PRICE: I have a few questions. What information do you have on file about your drug suppliers?

MR. JOHNSTON: What information do we have where?

MR. PRICE: On file, in your records about your drug suppliers?

MR. JOHNSTON: What type of information do you mean?

MR. PRICE: What information do you have, if any?

MR. JOHNSTON: Well mostly boils down to their catalogue and the invoices which are filed under accounts payable.

MR. PRICE: And their price.

MR. JOHNSTON: We don't have any information about the financial status of the company.

MR. PRICE: You have their price list?

MR. JOHNSTON: Price list and catalogue.



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MR. JOHNSTON: Price list and cata-



MR. PRICE: Do you have specific information about drugs?

MR. JOHNSTON: Oh yes, most manufacturers' price lists or catalogues are divided into two sections. The first section usually deals with pharmacological action of the different products that they sell and the second section is the price.

MR. PRICE: Have you ever been supplied inferior drugs?

MR. JOHNSTON: I can't recall any within the last ten years. I am very careful where I buy the drugs.

MR. PRICE: Have the doctors ever complained about any drugs?

MR. JOHNSTON: No sir.

MR. PRICE: Has your pharmacy ever been burglarized?

MR. JOHNSTON: No sir.

MR. PRICE: Do you insure your drug stock?

MR. JOHNSTON: We have a general floater policy that covers all the hospital against pilfering.

MR. PRICE: Do specific drugs sometimes prove to be superior to similar drugs?

MR. JOHNSTON: You mean two different drugs made by different manufacturers, is that what you mean?

MR. PRICE: Yes.



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MR. JOHNSTON: Not to my knowledge.

MR. PRICE: Have you ever had a doctor complain that a substitution was not as good as the drug he had prescribed?

MR. JOHNSTON: We have never had such a complaint at our hospital sir.

MR. PRICE: Has the Hospital Services Commission ever been critical of your drug purchases?

MR. JOHNSTON: No sir.

MR. PRICE: Mr. Johnston when you say that a manufacturer will sometimes shade a list price do you think this may reflect a reduction in price?

MR. JOHNSTON: Yes, when I say shade, I mean he will quote a price which is lower than the published price in his catalogue.

MR. PRICE: It may mean that the price has been reduced since the catalogue?

MR. JOHNSTON: That is true. The price may have been reduced since the catalogue was printed. That is right.

MR. PRICE: Coming back to a previous question, what would you have done if the doctor had insisted upon the pills prescribed and none were available except by purchasing a greater supply than your immediate needs?

MR. JOHNSTON: We would have bought the greater supply. There is no alternative. We have to supply, if the doctor does not agree to use some other.



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MR. JOHNSTON: Yes.

MR. PRICE: Mr. Johnston when you say

that a manufacturer will sometimes shade a list price

do you think this may reflect a reduction in price?

MR. JOHNSTON: Yes, when I say shade,

I mean he will quote a price which is lower than the

published price in his catalogue.

MR. PRICE: It may mean that the price

has been reduced since the catalogue?

MR. JOHNSTON: That is true. The price

may have been reduced since the catalogue was printed.

That is right.

MR. PRICE: Coming back to a previous

question, what would you have done if the doctor had

insisted upon the pills prescribed and none were

available except by purchasing a greater supply than

your immediate needs?

MR. JOHNSTON: We would have bought

the greater supply. There is no alternative. We

have to supply, if the doctor does not agree to use

some other.



MR. WHITE: I have a few questions Mr. Chairman. Mr. Johnston you mentioned in your brief that where drugs are listed on the British Pharmacopoeia or the U.S.P. that the competition is made greater. I don't understand that. I wonder if you would elaborate on it.

MR. JOHNSTON: Well as a rule these are not what you might call branded name drugs. As a general rule under the - there are exceptions. One exception - well several, but I can give you an exception, for instance the drug pathedine is called in the United States meperedin. Pathedine has been in a pharmacopoeia, I am sure, for at least ten years. I can buy it over in Britain made by Abbotts, British Drug Houses, Glaxo Allenburys or any one of a number of manufacturers and all these reputable firms have all kept the price - I beg your pardon - they all kept the quality up to the suppliers of the pharmacopoeia and there was competition within the various companies sometimes on a contract price or other volume buying.

Now I find that when I came here in 1948 I couldn't buy it under the name of pathedine. You couldn't buy pathedine but you could buy demerol brand of pathedine which is only made by one company and there was no competition.

MR. WHITE: Would there not be other brands of pathedine?

MR. JOHNSTON: No, it was forbidden to



MR. WHITE: I have a few questions Mr.

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MR. JOHNSON: Well as a rule these

are not what you might call branded name drugs. As a general rule under the - there are exceptions. One exception - well several, but I can give you an exception, for instance the drug paraffin is called in the United States paraffin, paraffin has been in a pharmacopoeia, I am sure, for at least ten years. I can buy it over in Britain made by Abbott, British Drug Houses, Glaxo, Alkermes or any one of a number of manufacturers and all these reputable firms have all kept the price - I beg your pardon - they all kept the quality up to the suppliers of the pharmacopoeia and there was competition within the various companies sometimes on a contract price or other volume buying.

Now I find that when I come here in

1948 I couldn't buy it under the name of paraffin. You couldn't buy paraffin but you could buy demerol brand of paraffin which is only another name and there was no competition.

MR. WHITE: Would there not be other

brands of paraffin?

MR. JOHNSON: No, it was forbidden to



be made by any other company. I may be wrong. I got the impression nobody else could sell it in this country as long as they had this registered trade name.

MR. BRYDEN: Nobody could sell it under that name but surely under something else?

MR. JOHNSTON: There was no one else selling pathedine until last year.

MR. BRYDEN: What company put out demerol?

MR. JOHNSTON: Winthrop Stearns.

MR. WHITE: How would the price of demerol compare with the price of pathedine that you had been charged in England?

MR. JOHNSTON: Speaking only from memory again since it came on the market it is now handled from several sources - whether it is made here or whether it is manufactured in Great Britain and imported and bottled or finished here, I don't know but I would say right now we buy 30 cc. vial for 40 cents total, less than \$40 a 100 vials.

MR. WHITE: Less than it was a few years ago?

MR. JOHNSTON: Less than it was just immediately prior to importation until this patent expired.

MR. BRYDEN: Is the product you are now buying imported or manufactured here?

MR. JOHNSTON: I don't know sir.



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got the impression nobody else could sell it in

this country as long as they had this registered

under that name but surely under something else?

MR. JOHNSTON: There was no one else

selling anything until last year.

MR. BRYDEN: What company put out

remedy?

MR. WHITE: How would the price of

demand compare with the price of medicine that

you had been carrying in England?

MR. JOHNSTON: Speaking only from

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MR. BRYDEN: Is the product you are

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MR. JOHNSTON: I don't know sir.



MR. WHITE: What company ---

MR. JOHNSTON: There are two companies distributing it that I know of - perhaps many others but the two that I know of are British Drug Houses and Glaxo Allenburys.

MR. WHITE: What percent of the 40 cents is that? 10%?

MR. JOHNSTON: It's a reduction I would say from \$1.56 to \$1.16.

MR. WHITE: Is it still higher than you were paying in England do you know?

MR. JOHNSTON: Oh very much so. I find that on the average prices here were three or four times as high as they were in the United Kingdom for drugs; drugs that I know over there I would have quoted the equivalent of nearly 35 cents were selling here for about 95.

MR. WHITE: These are manufacturers' prices in both cases?

MR. JOHNSTON: Manufacturers' prices, I am not referring to the retailer.

MR. WHITE: You are not referring to the British Health Service?

MR. JOHNSTON: No, no. I am not referring to that. Just referring to the price from the manufacturers.

MR. WHITE: Manufacturers' price to hospitals here and in England and it is two or three times as high here?



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MR. WHITE: What percent of the 40

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MR. JOHNSTON: It's a reduction 1

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MR. WHITE: Manufacturers' price to

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times as high here?



MR. JOHNSTON: No, I didn't say manufacturers' price to hospitals. I said manufacturers' prices as a general rule. Now I am talking about manufacturers' prices here to the retail pharmacy, chiefly.

MR. WHITE: Three or four times as high here?

MR. JOHNSTON: They were. Now that was in 1948. Of course I understand there has been a big inflationary trend in Britain since I left and perhaps it has come up now to maybe twice or one-and-a-half times.

MR. WHITE: Have there been any price decreases here in the last year? Have you noticed a price decrease here in the last year?

MR. JOHNSTON: There have been a few price decreases on the established products but I notice that most new products that come on the market seem to be high-priced.

MR. WHITE: If I could proceed here with these questions do you purchase from any drug wholesaler such as Drug Trading Company?

MR. JOHNSTON: Yes, we do.

MR. WHITE: Do you get the semi-annual rebate?

MR. JOHNSTON: Yes, we do.

MR. WHITE: And is that identical to the retailers' rebate, do you know?

MR. JOHNSTON: Yes as far as I know it

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is.

MR. WHITE: About 10%?

MR. JOHNSTON: Approximately 10%, yes.

MR. WHITE: When you buy a drug that is sales tax exempt, do you reclaim the tax from the Federal Government or do you certify your orders?

MR. JOHNSTON: We certify our orders and they are billed with the tax deducted from the price, the invoice price.

MR. WHITE: Would it show a list price less the hospital discount less a certain percent for sales tax?

MR. JOHNSTON: In some cases they do it that way. Other cases, some companies have already got the net price worked out with the tax taken off and it is billed as a straight price, sales tax not included, might find sales tax included but this is always shown. If it is shown you write and request a rebate.

MR. WHITE: Have you ever tried to determine whether the sales tax in the not-included price happens to be identical to the sales tax-included price? We learned this was from one manufacturer last week that in effect he was better off by the amount of the tax.

MR. JOHNSTON: I am not aware of any manufacturer that we buy from that doesn't give us the tax exemption. Perhaps we don't buy from this manufacturer.



MR. WHITE: About 1965

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MR. JOHNSTON: I am not aware of any manufacturer that we buy from that doesn't give us the tax exemption. Perhaps we don't buy from



MR. WHITE: What is the percent of the sales tax rebate?

MR. JOHNSTON: Well the sales tax, as you know, that must be forwarded to the Federal Government, is 11% of selling price or the cost price, I should say. Now some manufacturers, if you work this out backwards the decimals come out approximately 9.99 or something like that. Some people give you 10 off, some give you 9 off.

MR. WHITE: What does the wholesaler give you?

MR. JOHNSTON: The wholesaler gives us, if we buy from Drug Trading we get 6% off. Now this is done as a bookkeeping convenience because from Drug Trading we purchase many other items besides pharmaceuticals and they have statistically or actuarially worked out their average cost of sales tax for these items and it works out to 6%.

The same thing applies to National Drug Company and they give us 6%. This is because sales tax on a number of items, I understand, like stationery and paper goods some retail druggists handle is based on different - it's assessed on a different basis. It's based on the cost of manufacture. I think it depends on whether the wholesaler collects the tax or whether the tax is collected at the manufacturers' level, and passed on and the wholesaler would then pay it, tax-included price in which case he couldn't very well arrange -

MR. WHITE: What is the percent of the

sales tax rebate?

MR. JOHNSTON: Well the sales tax, as

you know, that must be forwarded to the Federal Government, is 1% of selling price or the cost price, I should say. Now some manufacturers, if you work this out backwards the decimals come out approximately 9.99 or something like that. Some people give you 10 off, some give you 9 off.

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I guess he could arrange without too much trouble -
so on the average it works out to 6%.

MR. WHITE: And this is true of all
wholesalers? They credit you 6%?

MR. JOHNSTON: Well we only deal with
two and that is National Drug and Drug Trading.
Incidentally, getting off the subject of drugs, if
we buy china and stationery and other goods like
that, it's 5 or 6% tax we get back.

MR. WHITE: Mr. Breel led us to believe
he gets 25% discount on all drugs he buys from retail-
ers but you have mentioned you just get 25% on ---

MR. JOHNSTON: When we buy full
bottles we get 25%. If the retailer breaks a bottle,
charges us the retail price.

MR. WHITE: I wonder if Mr. Breel meant
that he got 25% ---

MR. JOHNSTON: I don't know. We didn't
discuss it prior to this.

MR. WHITE: Now when any used drugs
are returned to the pharmacy, I suppose there is some
danger of contamination while it has been out in the
ward?

MR. JOHNSTON: No. You are suggesting
that perhaps the drug has been near a patient with a
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MR. WHITE: You mentioned the desirability of having a public analyst - a drug manufacturer suggested to us last week that hospitals in calling tenders of their drug requirements as part of the tender specification they could ask for an independent testing laboratory report.

THE CHAIRMAN: A certificate idea.

MR. WHITE: Yes. I wondered if you would consider this possible? I suggested at the time that the cost of the report might more than offset the additional cost of, or rather might more than offset the savings involved in the lower price resulting from the tender calling.

MR. JOHNSTON: I think if the hospital was going to have this analysed generally it would be prohibitive for us.

MR. WHITE: Have to be a larger hospital you think?

MR. JOHNSTON: Small quantities that we handle.

MR. WHITE: Now I just would like to clarify: if drugs become obsolete you can return them for full credit can you if the container is not



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clarify: if drugs become obsolete you can return

them for full credit can you if the container is not



open?

MR. JOHNSTON: If the container is not open - different companies have different policies but normally within three years you get full credit and up to five years they could give you half credit. After five years there is nothing.

MR. WHITE: I recall Mr. Chairman when we were discussing this with the manager of the Association he certainly left the thought in my mind they gave full credit for everything any time.

MR. JOHNSTON: Not if the box has been opened sir.

MR. WHITE: And even if the box has not been opened after four years you go back you would only get half?

MR. JOHNSTON: As I say, it varies with different companies but with most of the big companies that has been my experience.

MR. WHITE: Am I correct in thinking that you said the cost per patient, drug per patient day was 80 cents?

MR. JOHNSTON: It was roughly 80-some odd cents, I don't know, 83, 86, something like that during last year. This year it is higher.

MR. WHITE: And salaries for dispensing would be extra?

MR. JOHNSTON: Salaries are - that is just the drug - salaries would be extra.

MR. WHITE: Your costs are really around



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95 cents or a dollar?

MR. JOHNSTON: I doubt if it would be that high because our salary bill, as you can see, is only \$3 an hour for part-time, about \$45 a week, multiply that by 52 and divide by 22,000 would get the cost of salaries per patient day. I can't do it in my head.

MR. WHITE: Now Mr. Wren made reference to this matter of substitution of drugs from your formulary for a drug prescribed by a doctor which is not in your formulary and I would judge that the cross-reference index which you kept is the crucial part of this substitution procedure. Would it be possible for the Committee to obtain a copy of your formulary list and a copy of the cross-section or is that difficult to?



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is that difficult too?



MR. JOHNSTON: It would be very difficult. First of all, our formulary, which we started working on a year ago, is not yet complete. The cross-reference is kept in the pharmacy and is in the form of index cards, and is not in the form of a book, and there is just one copy in the hospital.

MR. WHITE: Is there one index card for each drug?

MR. JOHNSTON: For each name.

MR. WHITE: If you look up Brand A, would it refer you to such and such?

MR. JOHNSTON: It would refer you to Brand B, C and D, and give you the generic or official name.

MR. WHITE: Do you stock under brand name?

MR. JOHNSTON: We stock both ways. For instance, demerol, a strange supervisor was on and this is unusual because we don't usually run out of supplies at night, a strange night supervisor came along with an order for demerol and looked up this index under demerol and it said pethidine BP and meperidine USP, and she flipped the cards for pethidine and found demerol. In addition, the pharmacy is divided into sections, A, B, C and D alphabetically, and in each section are numbered drawers, so you might find the demerol under B3.

MR. WHITE: Would the demerol card



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A, B, C and D alphabetically, and in each section

are numbered drawers, so you might find the Demerol

MR. WHITE: Would the Demerol card



show that location?

MR. JOHNSTON: It would show on all of them.

THE CHAIRMAN: Mr. White, would this be a convenient time for us to have a five minute recess?

MR. WHITE: Yes.

---A short recess

MR. RICE: Mr. Chairman, are there any other members of the Committee with questions for Mr. Johnston?

MR. WREN: Acting as purchasing agent, I suppose, in your office as administrator, what do you find in hospital supplies such as syringes, instruments and so on? Do you find the prices there excessively high?

MR. JOHNSTON: It depends on what type you buy. There is a variance in price.

MR. WREN: What is the variation?

MR. JOHNSTON: I couldn't say offhand. You would have to compare competitive qualities, but there is a variation.

As far as function goes, often the cheap syringe will perform as well as a more expensive one. There may be differences in the length of time you could use the cheap syringe. As you mentioned syringes, this is an example I



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am using, because there are graduations engraved on this glassware, and there are special pigments used to make them legible, and it has been found with some that the graduations wash off when the syringes are soaked in the antiseptic solutions, or sterilized. The same thing applies to thermometers.

MR. WREN: But in a given product, is there a wide variation in prices?

MR. JOHNSTON: We have very few manufacturers. I don't know any in Canada, most are from the United States, and distributed by jobbers, and the prices are very close. The differences usually being attributable to the distance the product is shipped to the hospital.

MR. WREN: But in a given location?

MR. JOHNSTON: We only have one firm to get quotations from in our area. That is a company in Windsor with a branch in Detroit. We have found we can get cheaper prices from the Windsor firm than in Toronto. Conversely, we have found we can purchase surgical equipment more cheaply from Toronto than in Windsor.

MR. WREN: Is the competition keen pricewise?

MR. JOHNSTON: Competition is very, very keen.

MR. WREN: With regard to prices?

MR. JOHNSTON: Very, very competitive,

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yes. When we require instruments we usually accumulate these requirement until we have a sizeable order, not sizeable for a large hospital perhaps but sizeable for our hospital. Two or three hundred dollars is a very sizeable order for instruments for us. We will list all the instruments as per a specification and send out copies to the jobbers or wholesalers and we find some have quoted cheaper on one article and others cheaper on other articles, and we will circle the cheaper articles and send the order to the five or six people bidding.

MR. TROTTER: Although the number of beds has gone up from 51 to 91, I notice that the price of drugs per number of patients per day has gone up?

MR. JOHNSTON: There is an explanation for that. We had only 29 medical and surgical beds before expansion, and now have 59. That is more than double. We also have another bed set up, you can say we have 60 medical and surgical beds. It is in the medical and surgical beds that you use the drugs. The other departments, for instance in our maternity department which has very moderately increased from 18 to 22 beds, that is all, and there is practically no drugs used in that department.

MR. TROTTER: In the overall picture, how much more cheaply do you think a large hospital can buy drugs than your hospital can?

MR. JOHNSTON: This is based on volume.



Yes. When we require instruments we usually accumulate these requirement until we have a sizeable order, not sizeable for a large hospital perhaps but sizeable for our hospital. Two or three hundred dollars is a very sizeable order for instruments for us. We will list all the instruments as per a specification and send out copies to the jobbers or wholesalers and we find some have quoted cheaper on one article and others cheaper on other articles, and we will circle the cheaper articles and send the order to the five or

MR. TROTTER: Although the number of

beds has gone up from 51 to 91, I notice that the price of drugs per number of patients per day has gone up?

MR. JOHNSTON: There is an explanation

for that. We had only 29 medical and surgical beds before expansion, and now have 59. That is more than double. We also have another bed set up, you can say we have 60 medical and surgical beds. It is in the medical and surgical beds that you use the drugs. The other departments, for instance in our maternity department which has very moderately increased from 18 to 22 beds, that is all, and there is practically no drugs used in that department.

MR. TROTTER: In the overall picture,

how much more cheaply do you think a large hospital

can buy drugs than your hospital can?

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You are referring to an institution such as the Toronto General?

MR. TROTTER: Yes?

MR. JOHNSTON: I would assume they make appreciable savings on most products, because even the brand name drugs listed in catalogues you will notice, if you examine the prices, the prices progressively decrease as you go from 100 to 500 to 1,000. We are unable to avail ourselves of these lower prices, because a hundred of a certain drug might last us six months, but they might use 5,000 in the Toronto General, so we are pegged at the highest price.

MR. TROTTER: You mentioned in England that drugs were four or five times cheaper when bought by the pharmacist from a drug manufacturer. The prices may have changed from the time you were over there, but could you give us reasons why the drug prices seem to be so much cheaper in Great Britain?

MR. JOHNSTON: I couldn't give any reason myself. My only thoughts on the matter were that this is a high priced economy over here, living at a high standard of living perhaps, higher than over there. I also could say that the average salaries here are double the average salaries in the United Kingdom.

MR. WREN: Does that reflect itself in prices here? Are drugs purchased from British



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MR. WREN: Does that reflect itself
in prices here? Are drugs purchased from British



drug houses as opposed to American drug firms any less in Canada?

MR. JOHNSTON: As a rule they are.

MR. WREN: So it is preferable to buy the equivalent drug from a British house if it is available?

MR. JOHNSTON: Well, either British or French or German or even American if it is lower. We buy from whichever we get the lowest. We don't make any preference on the basis of nationality.

MR. WREN: But British prices are generally lower than American?

MR. JOHNSTON: We have found that several firms are.

MR. BRYDEN: One of the most sensational cases of high prices in Canada was chlorophenol, and the Canadian product comes from France, where the wage factor would be even less than the United Kingdom.

MR. JOHNSTON: That is correct. The same applies to the Volkswagen cars.

MR. BRYDEN: But this drug is sold in Canada at the highest price in the world.

MR. WHITE: From your observation, would you think that the North American drug houses spend considerably more money promoting their products than they do in England?

MR. JOHNSTON: I couldn't give any comparison, it being so long since 1947 when I left.



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I don't know what they are doing today in Britain. It was just after the war and they were picking up the pieces, but there is no question about it that the money is spent on that.

MR. WREN: Were you a pharmacist in Britain?

MR. JOHNSTON: Yes.

MR. WREN: What was the pattern in Britain before the health scheme in the sale of drugs? Was the promotion a watchword like it is here?

MR. JOHNSTON: Yes, there was promotion. You were probably aware that there was a national formulary which was a book of recipes, and doctors generally confined their prescribing to this formulary, with the exception of specific drugs which they could justify to their local council or committee, who were supervising the dispensing of drugs.

MR. WHITE: I understand other countries have a national formulary also, Sweden being one. There is no such thing in Canada or the United States?

MR. JOHNSTON: Well, for the reason of course we don't have a national health insurance plan. The formulary was brought in to restrict prescribing.

MR. BRYDEN: In other words, it is much the same idea as your hospital formulary,



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only on a larger scale? They want to keep control over prescribing drugs?

2 MR. JOHNSTON: That is correct. The difference is there is more authority. As I understand it, the committee which operates this in other countries, and also in closed staff hospitals in the United States. Do you know what I mean by closed staff hospitals, where the doctors are only allowed to practise there provided they comply with the rules of the hospitals, which may be restrictive on their prescribing habits. In these institutions, and with these national formularies, a doctor must limit himself to it, unless he can prove his patient requires another drug. He must prove this clinically to some representative of their formulary committee, and that person representing that formulary committee might say no, you are not going to use that drug, we are not going to buy it. We don't believe it is any good or will do what you claim for it.

MR. BRYDEN: What are the types of people who would make up the formulary committee

MR. JOHNSTON: Whereabouts?

MR. BRYDEN: Say in Britain, are you familiar with that?

MR. JOHNSTON: No, not at the present time, but in the closed staff hospitals in the North American continent it is members of the



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medical staff themselves. They are a self-governing body.

MR. BRYDEN: Wouldn't it be possible in Canada to develop something similar to that, even without health insurance? I am in favour of health insurance myself, but leaving that issue aside, wouldn't it be possible to have some sort of a committee of experts who would study drugs and consider their efficacy for various types of treatment, make information available so that the doctor does not have to rely on the detail men or the promotional literature that he gets in the mail, or read all the authorities and articles which he clearly has not time to do. Why couldn't information be made available to doctors in a condensed form, in the same principle as under a formulary.

MR. JOHNSTON: This body would possibly, you are suggesting testing the purity or strength of the drug?

MR. BRYDEN: No, from the clinical point of view, because that is the critical point?

MR. JOHNSTON: That is true.

MR. BRYDEN: One naturally follows the doctor's prescription, but doctors are human. I read an article where for one preparation it would have been necessary to read 98 articles in various medical publications. Couldn't we work out a system whereby somebody would do that for the doctor?



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MR. JOHNSTON: Yes, but if the material is still on the market, the doctor is still free to order it.

MR. BRYDEN: But at least he would get a little more reliable information?

MR. JOHNSTON: If he needed it.

MR. BRYDEN: There is a publication in the United States in the Medical Letter. It is true he does not have to read it, he could if he wanted to, which attempts to evaluate the claims made for the drugs.



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MR. JOHNSTON: I think the lines of new drugs are succeeding each other so rapidly, that as you have mentioned earlier, the doctors can't keep up with the sort of information that is being poured out. Many of the uses of the drugs, in my opinion, I feel that they are trying something, keep on trying. Of course there is no doubt they are trying to give their patients the best treatment they can, and we must not forget the doctor is under terrific pressure from their relatives or from the patients themselves to use a certain drug that was read about.

MR. BRYDEN: The Reader's Digest wants to prescribe itself?

MR. JOHNSTON: It could be. There is no question about it, there is pressure on the doctor, but not only for drugs, but everything. There is pressures on doctors who operate, and the doctor often has to fight the relatives off because he feels an operation would not be justified.

There are also pressures to perform certain laboratory tests. Doctors are under all the pressures. I don't envy the medical man at all.

MR. WHITE: May I ask one or two questions about the U.S. and British Pharmacopoeia? First of all, who publishes those two pharmacopoeia, the governments of the countries?

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Pharmaceutical Society of Great Britain, which is a statutory body, and I would assume the United States Pharmacopoeia -- I don't know whether it is a publication of the Food and Drug Act administration, or whether it comes under the pharmaceutical body.

MR. WHITE: There is no Canadian Pharmacopoeia?

MR. JOHNSTON: There is a Canadian Formulary, but the British Pharmacopoeia is adopted as the standard for purity, strength and so on right around the British Commonwealth.

MR. WHITE: Who publishes the Canadian Formulary?

MR. JOHNSTON: I don't know. I would hazard a guess possibly perhaps by the Canadian Pharmaceutical Association, but I don't think. I think that is more of a trade organization. I don't know whether they would publish it not.

It may be a publication of the Department of Health. It is very rarely used, and seldom if ever referred to.

MR. WHITE: When your hospital sends out an order to a supplier using the British Pharmacopoeia, would you show a number, or just how do you relate it to the British Pharmacopoeia?

MR. JOHNSTON: We indicate we wish British Pharmacopoeia quality by putting the B.P. after the name of the drug. For instance, if



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we were ordering what we referred to as aspirin, it is a trade name, and we order tablets of acetylsalicylic acid B.P.

MR. WHITE: You mentioned earlier that if you specified B.P., then the supplier is obliged to put that on the label?

MR. JOHNSTON: That is correct. He is not obliged to put it on the label. He is obliged to supply us with B.P. quality, and if he does, he should show that.

MR. WHITE: Whether or not he shows it on the label, he is legally obliged to provide the quality?

MR. JOHNSTON: Yes, but he may not necessarily do so. If the label comes in and it doesn't have B.P. on it, we would send it back.

MR. WHITE: If it has B.P. on the label, and it doesn't measure up to that quality, he may be --

MR. JOHNSTON: He is liable to be sued. He would be responsible for any damages arising out the use of that.

MR. BRYDEN: The chances he would be discovered are not great, are they, because the customer is not going to analyze the product in all probability.

MR. JOHNSTON: That is correct. He will not do a chemical analysis, but we can tell -- I am speaking personally as a pharmacist -- we



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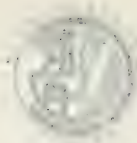
can tell fairly closely after looking at drugs for 20 or 25 years, if it is off colour or off smell or crystallizing. And you can get some indication, and certainly if it looks a little bit dubious, and if there is precipitation or cloudiness, we just wouldn't use it.

MR. BRYDEN: Except that what I am getting at, the possibility of a suit or prosecution, whatever it may be, is not very serious because even if you found one you questioned, instead of going to all the trouble of having it tested and launching legal action, presumably your action would be simply to return it?

MR. JOHNSTON: That is correct. I was speaking in the sense of some error on the part of the manufacturer; perhaps the strength not being as labelled, not according to the B.P. strength, and in the event of some injury being done to the patient with this drug. The hospital of course would be liable for public liability and malpractice, and in that event of course the responsibility would be placed on the pharmacy providing the doctor had used the drug within normal methods of use.

MR. RICE: Have you any questions, Mr. Price?

MR. PRICE: Yes. We have heard that the quality and the discounts and the return privileges are pretty much the same with companies, and we have also heard of competition for your



can tell fairly closely after looking at drugs for 20 or 25 years, if it is off colour or off smell or crystallizing. And you can get some indication, and certainly if it looks a little bit dubious, and if there is precipitation or cloudiness, we just wouldn't use it.

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business. Now, it seems to me the companies must be providing other services that would influence you to make a purchase, say one company or prefer one company rather than another company. Can you tell us what those other services or other factors might be in preferring one company to the other?

MR. JOHNSTON: The basis we use is quality, first of all. The price and the delivery date.

MR. PRICE: Is that a factor?

MR. JOHNSTON: That is definitely a factor because a firm may be able to supply a drug at a lower price, but if they don't have it in stock, it isn't much good to you.

MR. PRICE: Are there any other factors?

MR. JOHNSTON: No, that is fundamentally it. I don't know exactly what answer you want me to give you, but I would class under price the fact that some manufacturers do make a special concession to the hospitals. They do supply tablets and drugs at a lower price to hospitals than they would supply it to the retailer of drugs.

MR. PRICE: There are many factors that are identical. Obviously it boils down to service, if one company can give you better service -- you say better delivery dates?

MR. JOHNSTON: That is right.

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call around and give you other information? They must have other services they can give.

MR. JOHNSTON: If the price and quality is identical, and if we assume that the service or delivery date is identical, we may -- the manufacturer from whom we purchase this particular item may be dictated by the fact that there is something else going. Another drug being ordered from this manufacturer.

Supposing we had ordered an article from Schering Corporation, and the identical drug was made by Merck, and if we had an order going to Merck's for one particular drug, we wouldn't send another separate order to Schering if the price was identical. We would put them all on the same order. That is just common sense to save checking of the slips. Unless there is some gain to the hospital, we wouldn't split the order.

MR. PRICE: Do you find the service one company will give you very much the same as another, or does one company look after your business better than others?

MR. JOHNSTON: No, I wouldn't say. They are all about the same. They all give very good service. If we are short of drugs or an emergency, we will wire.

THE CHAIRMAN: Wouldn't some companies specialize in one particular drug? In other words, you have a choice of sorts?



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MR. JOHNSTON: That is correct. There are some drugs, for instance, as I mentioned earlier, somebody mentioned tetracycline. There are really three groups. One is called aureomycin. That is Lederle's, and tetramycin, that is Lederle's too. The other one is Terramycin. They are just different radicals attached to the tetracycline, but our choice is limited somewhat by the fact that there are only one or two manufacturers distributing those.

MR. BRYDEN: The Department of Defence Production at Ottawa has mass purchasing for all D.V.A. hospitals, drugs and other commodities. The result of that is they not only get discounts, the quantity discounts that the manufacturers advertise, but as I understand it, in many cases they do substantially better than that by calling for tenders, and naturally manufacturers want large orders such as they are placing.

Would it be possible for the same sort of thing to be done for general hospitals in Ontario? All the purchases would be consolidated, or at any rate, some of them, through some agency similar to the Department of Defence Production? If it could be done for a group of federal hospitals, why can't it be done for another group of hospitals?

MR. JOHNSTON: I would say it might be done for certain items, for certain items that are used in volume, but when you think of our

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little pharmacy -- we have something in the region of 10,000 different items some of which are only used once a month and some three times a year, that a large volume, a large number of individual items that we use are small quantity.

MR. BRYDEN: But even those, if the requirements of your hospital were consolidated with the requirements of other hospitals, it may become fairly substantial?

MR. JOHNSTON: That is true, but as I say, some may be using only 100 tablets a year. It would be pretty cumbersome.

MR. WREN: The D.V.A. hospitals in the main are large institutions, whereas the Ontario hospitals or Ontario General hospitals are in the main small institutions?

MR. BRYDEN: Some are small and some are large. D.V.A. are all large ones actually, which by themselves, I would imagine would get some concession, but they even go further and consolidate purchases.

MR. JOHNSTON: I don't know about the D.V.A., but I would be under the impression that they have a formulary and the doctors stick to a certain specified list of drugs.

MR. BRYDEN: I think that is true.

MR. JOHNSTON: Except in the case where they can prove to the pharmacy committee they need this. If you get the doctors restricted to a

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the main are large institutions, whereas the Ontario

MR. WREN: The D.V.A. hospitals in

would be pretty cumbersome.

say, some may be using only 100 tablets a year. In

MR. JOHNSTON: That is true, but as I

fairly substantial?

the requirements of other hospitals, it may become

requirements of your hospital were consolidated with

MR. BRYDEN: But even those, if the

that we use are small quantity.

a large volume, a large number of individual items

used once a month and some three times a year, that

of 10,000 different items some of which are only

little pharmacy -- we have something in the region



certain cast iron list of drugs, we can buy in quantity and put them in stock, and if you want anything else, you have to go and dig for it. We don't do that. That is interfering with the practise of medicine.

MR. BRYDEN: I don't think in D.V.A. they interfere with the practise of medicine, but they do restrict freedom of choice when it becomes meaningless. Would that be fair?

MR. JOHNSTON: I don't know. That is probably how they would work.

MR. FULLERTON: I realize you have to depend on the local drug store for a lot of your service in the smaller hospitals such as you have, and if you depended solely on your wholesaler medium for the small prescriptions, the smaller drug store would not be inclined to stock them.



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MR. JOHNSTON: Well, I think that the small drugstore doesn't really consider the hospital, certainly not when they decide whether they will stock a drug. This decision in my experience is usually based upon the fact that a detail man has been in the district and he will tell the pharmacist that he has told the doctors in the town about this new drug and he would recommend they get some in stock. The druggist will then put in one or two small packages of this. It is in these gratuitous circumstances we find that the doctor may order not for his office but for a hospital patient.

MR. FULLERTON: It might be an item you wouldn't ordinarily be inclined to stock?

MR. JOHNSTON: I beg your pardon?

MR. FULLERTON: It might be an article you wouldn't be inclined to stock?

MR. JOHNSTON: That is correct. There are very many articles which you might say would be normally for office use, that is to say the doctor would write a prescription for it for a simple type of complaint you would treat at home, containing medicine you would have dispensed from the drugstore. This type of thing we don't have. We feel when people come in the hospital we should have the other type of medicine which is usually used in the hospital for seriously ill people. We try and get a stock of these things, but these other multitudinous items we buy as we need them.



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MR. FULLERTON: What I was suggesting, you do rely on the local drugstore for a certain amount?

MR. JOHNSTON: That is right, about \$25 to \$30-worth a month.

THE CHAIRMAN: When we get down to the basic issue which is before us, we are talking about the cost of drugs, how all this might refer to the saving that might be effected - that is what we are really talking about, are we talking about \$200 or about \$20,000? I gathered from your earlier evidence, Mr. Johnston, you were talking about a possible saving of \$200 to \$300 as against \$17,000.

MR. JOHNSTON: That is what you asked me to give you the figure on, wastage, drugs thrown out that become obsolescent.

THE CHAIRMAN: Yes.

MR. JOHNSTON: But we have a lot of drugs in stock which have very little turnover. They are kept there for four or five years, and in the meantime new drugs will be used in place of these, whereas if we could get down and like Mr. Bryden mentioned, to a basic list of drugs that would simplify purchasing and it would reduce the amount of drugs that we have to carry in stock.

THE CHAIRMAN: What do you estimate the saving would be if you could do that?

MR. JOHNSTON: If you went the whole way in the formulary such as mentioned in Sweden



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THE CHAIRMAN: What do you estimate

the saving would be if you could do that?

MR. JOHNSTON: If you want the whole

way in the formulary such as mentioned in Sweden



and Great Britain, I would say you would save at least half the cost.

THE CHAIRMAN: Then you have to relate that to the doctors, the theory of the doctors' right to prescribe.

MR. JOHNSTON: That is right. You would have complaints, of course, from potential patients saying they weren't getting the medicine the doctor ordered.

THE CHAIRMAN: Mr. Boyer? Mr. Whitney? Mr. Fullerton? Mr. Price?

MR. PRICE: How important is it, Mr. Johnston, do you think for the patient to get the medicine the doctor prescribes?

MR. JOHNSTON: Well, I can only say he should get what is prescribed by the doctor. If he has entrusted his life to the doctor he should expect to get the treatment that the doctor orders for him.

MR. PRICE: I think so too.

MR. JOHNSTON: I agree.

THE CHAIRMAN: Mr. Wren?

MR. WREN: No.

THE CHAIRMAN: Mr. Bryden?

MR. BRYDEN: No.

MR. RICE: Thank you very much, Mr. Johnston.

Mr. Chairman, we have two more witnesses scheduled for this afternoon.



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MR. PRICE: Thank you very much, Mr.

Johnston.

Mr. Chairman, we have two more witnesses

scheduled for this afternoon.



THE CHAIRMAN: We had better go ahead.

MR. RICE: Mr. Ruth? Mr. Ruth is the administrator of the Baycrest Hospital which is the Chronic Hospital. For the purpose of the record would you give us your full name?

MR. RUTH: Simon Ruth.

MR. RICE: What is your occupation?

MR. RUTH: Hospital administrator.

MR. RICE: For which hospital?

MR. RUTH: The Baycrest Hospital.

MR. RICE: Where is that located?

MR. RUTH: Baycrest is located at 3560 Bathurst Street in Toronto.

MR. RICE: How long have you been administrator of that hospital?

MR. RUTH: Five years this July 15th.

MR. RICE: What did you do prior to that time?

MR. RUTH: Assistant administrator of the Mount Sinai Hospital at Cleveland for three years prior.

MR. RICE: And prior to that?

MR. RUTH: Prior to that administrative intern, administrative resident for two years at the Beth Israel Hospital in Boston.

MR. RICE: How long have you been associated with hospitals?

MR. RUTH: Ten years.

MR. RICE: What type of hospital is the



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MR. RUTH: Ten years.

MR. RICE: What type of hospital is the



Baycrest Hospital?

MR. RUTH: The Baycrest Hospital is a hospital treating people with long-term illnesses. Most of the people in our hospital are in the older age group. We rarely admit people under 35 to 40.

MR. RICE: How many beds would be in the hospital?

MR. RUTH: We have 87 beds.

MR. RICE: How many patients per year would be your turnover?

MR. RUTH: We admit approximately 250 people a year. We have 32,000 patient days.

MR. RICE: I understand you have some notes, some representations to the Committee in regard to drugs in your hospital.

MR. RUTH: First of all may I apologise to this Committee for not preparing a brief in detail. I wasn't aware of Committee procedure. The next Committee I am before I will know better.

We were asked to appear here because of two reasons, I believe. Number one, we are medically integrated with the New Mount Sinai Hospital, medical integration. The doctors on the staff of New Mount Sinai Hospital, as part of their agreement, they are serving voluntarily with their time at Baycrest Hospital. One of the reasons, since most of the patients in the chronic hospital are staff patients it is difficult to get doctors to cover this hospital because of these arrangements. We have been allowed



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to medically integrate. We get excellent medical coverage by the senior staff of the hospital. We also have a lot of people in the Home for the Aged, the Jewish Home for the Aged - on the third floor is Baycrest and on the first two floors is the Home for the Aged.

Most of my comments will refer to Baycrest Hospital because I believe that is our main interest here. Our total budget for Baycrest Hospital in 1960 was around \$389,000, the cost of drugs, \$13,641 and the cost per day 42 cents. This is lower than the average of \$1.01 of Class 'A' hospitals in this Province, but it is quite a bit higher than the average long-term hospital mainly because we are trying to give a lot of active treatment even to long-term cases.

Our procedure in purchasing, we have a pharmacist who works part-time, she supervises and our associate physician-in-chief who is a staff doctor; he is reimbursed for part of the time. It is really an honourarium in the sense he is reimbursed.

The procedure in purchasing drugs is, first of all, we have what we call a formulary committee who meet about twice a year. We have - I don't have it here but I will be glad to present it to the Committee Secretary for his records - a formulary indicating the drugs that doctors can order from the Baycrest Hospital. During the year new drugs keep coming out and with the constant attention of our



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physician-in-chief three or four times a week we keep up to date our formulary.

On the question of what happens when a doctor requires or prescribes a drug that isn't on our formulary; obviously in the case of a critical emergency we just do it and question him later. When I say "we" I mean the doctor. However, we do have a form for request of special drugs when it isn't on the formulary giving the name of the patient, diagnosis, name of drug, reason why this drug should be used rather than another, amount of drug required, duration, prescription of the drug and for what purpose it is used - this is when the attendant physician requests a drug from the associate physician-in-chief. I have a few of them with me. One is a small order and the duration is one to one-and-one-half month's trial. That is so we don't overload on some drugs when the doctor is trying a new drug. On the other hand we want to make sure we can meet the doctor's needs.

MR. WHITE: Doesn't the doctor accommodate to the formulary nearly all of the time?

MR. RUTH: In our hospital that is true. There may be a reason for that, and that is because most of our patients are staff patients. They are volunteer doctors. They are not - I am sure the treatment our patients get are as good as any given by any doctor to any private patient. I think it is a heritage of the out-patient department, the staff



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goes on the formulary and it is always used more readily than for private patients. They do accommodate themselves to the formulary. We have very few of these requests. However when they come in they are normally approved by the physician-in-chief. It preserves the doctor's right to order.

MR. WHITE: It is easier to use the formulary and 99 out of 100 times they would?

MR. RUTH: I think so.

In Boston we had a formulary by number. You ordered by number. If we got the wrong number it was awkward.

Distribution procedure, unlike other hospitals even prior to the Ontario Hospital Services Commission we had all-inclusive. We didn't break it down and charge for drug formulary etc. so when the Ontario Hospital Services Commission came in we just went right along with our previous scheme.

Rather than have individual prescriptions, a bottle for each patient on the floor, we have what we call a stock prescription that our pharmacist fills, and therefore we have one large bottle and the nurse has to take out what she needs. There may be a greater chance for error as she has to use her discretion. We have found we have had little or no problems in this matter.

Analysis of drugs - obviously we are a small hospital and we couldn't afford to analyse our own drugs. What we do, we take advantage of the



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New Mount Sinai Hospital much larger formulary and also contact other hospitals and we ask them do you use this drug, have you tried it? We do find that the Mount Sinai Hospital has asked for analysis on some. We have some newer manufacturing companies - I may get into trouble over this - you want to be sure you are protecting your patients by buying from people who have manufactured their drugs properly and I think there is a natural hesitancy about jumping into a newer firm. I find if the newer firms want to get into business and give you some kind of material at lower prices - this is the problem we had - we did get some laboratory reports and we try to pass this expense onto the new firm. If they want our business we feel they can give us these independent analyses. This comes to us...

MR. WHITE: From where?

MR. RUTH: The name of this company - Corban Pharmaceuticals.

MR. WREN: In Toronto?

MR. RUTH: I assume it is. I am not familiar with all these details as I would like to be. It is an independent report on these drugs.

About half a year ago or a year ago when...

MR. WREN: Have you any idea what that analysis cost?

MR. RUTH: I am sorry, I don't. I could find that out for the record.

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About a half-year or year ago when all this publicity about generic drugs and trade names came up we started investigating our own purchasing habits. We felt by buying in bulk we might save some money. We had a little problem due to the size of the hospital. About three months later one of our solicitors got a clearance from the Department - I believe it is National Revenue, allowing us to purchase with New Mount Sinai Hospital. And we have been able to work with drug companies, where they will give us a year's supply of drugs on drop shipment to us and give us the advantage of the entire year's cost. We have found in many cases we do just as well as if we bought in greater bulk. I don't know how much we would save if we bought in tremendous lots. It seems to me there should be a saving there if our bookkeeping expenses didn't get out of hand. This we are investigating. Once again it is a matter of time since we now have the clearance from the Department.

We list our drugs, we ask them to check the prices of certain ones that come in, we just say take a firm that gives us the best price and buy from him. We go down the line and check each.



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We do purchase drugs from Drug Trading and I believe we do not get the advantage of the rebate because we don't have enough - there is another company we buy more drugs - I believe it is worthwhile investigating that to see if the discount would save the amount of the application; have to pay so much. Our Formulary Committee is made up of an Associate Physician in Chief, a member of the medical staff, a pharmacist and the Director of Nursing. As indicated, we meet two or three times a year. Since our key person, the doctor is around a great deal, we always have contact with him. We don't sell drugs to outsiders. Any questions?

MR. RICE: What price do you usually purchase - what discount do you get off the manufacturer's price list?

MR. RUTH: Looking at the average discount about 40 to 50%.

MR. RICE: And do you purchase from wholesalers?

MR. RUTH: We purchase from wholesalers and manufacturers and in the rare instances when someone needs something at two or three o'clock in the morning we will purchase from one of the pharmacists that have 24-hour service and we work out a very favourable arrangement with them on our discount. At times it is better than 25% maybe because this specific firm is interested in our hospital.

MR. RICE: When you say 25% discount



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very favourable arrangement with them on our discount.
At times it is better than 25% maybe because this
specific firm is interested in our hospital.
MR. RICE: When you say 25% discount



from the retailer - what is that 25% discount off?

MR. RUTH: It is off the retail price.

MR. RICE: What discount do you receive from wholesalers?

MR. RUTH: I don't know the exact discount. I will have to check. I think it was one-third. I will check that out and give it specifically.

THE CHAIRMAN: Mr. Rice the witness has stated that against a budget of \$389,000, \$13,641 was their drug bill within the area, meaning drugs, prescription drugs?

MR. RUTH: Yes sir.

THE CHAIRMAN: In the spirit in which this Committee is considering it. What percent or what would you buy from a retail pharmacist?

MR. RUTH: If it went up to \$500 I would be surprised sir.

THE CHAIRMAN: It is not a factor at all?

MR. RUTH: No sir it would not be. We are lucky enough to be in Toronto where we have direct access to these houses.

MR. RICE: I take it that you have a dispensary or pharmacy?

MR. RUTH: Yes.

MR. RICE: How many different drugs would you stock in your dispensary?

MR. RUTH: I don't know the exact number sir. I will have to check that.



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number sir. I will have to check that.



MR. RICE: Who is in charge of your dispensary?

MR. RUTH: We have a part-time pharmacist who works 20 hours a week. I might say we only carry one brand name of any drug. We do not keep two brand names. We have kept our inventory down to just keeping one brand name.

If the pharmacist is not there, the supervisor and the head of the nurses have keys to the pharmacy. They are all registered nurses. Our pharmacist would compound drugs, the nurses will not.

MR. RICE: Since your hospital is a more specialized type of hospital would your drug prescription be more specialized too?

MR. RUTH: We find we have a good number of tranquillizers with our older population there. A number of pneumonias which would bring in the antibiotics, I guess some surgery. In the hospital I think probably our claim to fame might be tranquillizers more than anything else.

MR. RICE: Could you give us your estimate of the number of prescription drugs that you fill in a year?

MR. RUTH: Our prescriptions would not be in comparison to other ones because we have stock prescriptions. We will have one bottle of specific drugs at the nursing station and many patients will use this one. The nurse will take a pill out for any patients, therefore it's a stock prescription.



MR. RICH: Who is in charge of your

dispensary?

MR. RUTH: We have a part-time pharmacist

that works 20 hours a week. I might say we only

carry one brand name of any drug. We do not keep

two brand names. We have kept our inventory down to

just keeping one brand name.

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We use stock prescriptions. I can get that number for you too sir. I don't have that offhand.

MR. RICE: How do you charge for these drugs? Is it included in the hospital?

MR. RUTH: It's all-inclusive rates, part of the per diem cost. There is no specific charge to any patient.

MR. RICE: Do you have any system of substituting of drugs?

MR. RUTH: In our formulary, it's not a really big one, the substitution - as I tried to indicate in tetracyclines when you get into that factor the pharmacist has permission to go ahead and do that. The pharmacist has been there for 5½ years now and a certain amount of faith has been developed in her, and also she has a good discretion. When she has any doubt she will check with the physician in chief.

MR. RICE: I understand that you will file a copy of your formulary with the Committee?

MR. RUTH: Yes sir, I will. I will submit that and I will retype my brief and present that.

THE CHAIRMAN: When was the Baycrest Hospital founded?

MR. RUTH: It was founded in 1954.

THE CHAIRMAN: Can we regard it as a branch of the Mount Sinai Hospital?

MR. RUTH: We are autonomous. We are



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THE CHAIRMAN: When was the Haystack

Hospital founded?

MR. RUTH: It was founded in 1954.

THE CHAIRMAN: Can we regard it as a

branch of the Mount Sinai Hospital?

MR. RUTH: We are autonomous. We are



incorporated separately but before I arrived in Toronto and before the hospital opened the physicians very wisely and the Board of Directors felt that to give good medical care the best way for chronic disease hospital to do so would be to integrate it with the general hospital and since Lambert's Lodge and Municipal Home in the Toronto Western and we also have been privileged to have two interns rotating through Baycrest Hospital from New Mount Sinai which gives us 24 hours medical coverage, and of course this gives the intern in training a greater insight into working with term disease and working with older people.

MR. RICE: Are there any other questions Mr. Chairman? Members of the Committee?

MR. PRICE: Do you find Baycrest Hospital is sufficient for your needs?

MR. RUTH: No sir.

MR. PRICE: In size?

MR. RUTH: Thank you very much for the opportunity. We are on a fund-raising campaign to increase the hospital to 180 beds.

MR. PRICE: Can you tell me why you would deal with a firm like Drug Trading?

MR. RUTH: We have found that in smaller articles we can do just as well with the number of articles that we have to have.

MR. PRICE: Do you know of any case where the independent analysis of the drugs have



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MR. PRICE: Do you know of any cases

where the independent analysis of the drugs have



proven to be unfavourable?

MR. RUTH: I don't know. I want to check on that. I can certainly follow through and get a report on that.

THE CHAIRMAN: Thank you very much Mr. Ruth for coming down and assisting us.

MR. RICE: The next one we have Mr. Chairman is Mr. George E. Miller who is purchasing agent for the National Sanitarium Association Hospital. Mr. Miller, for the record would you tell us your full name?

MR. MILLER: George Edgar Miller sir.

MR. RICE: What is your occupation?

MR. MILLER: I am a purchasing agent for the National Sanitarium Association.

MR. RICE: How long have you been in that position?

MR. MILLER: Since June 1950.

MR. RICE: And what did you do prior to June 1950?

MR. MILLER: I hesitate to mention it sir. I was the originator and publisher and editor of Silt, the Lands and Forests Review; for five years I had that privilege.

THE CHAIRMAN: That is a very good magazine.

MR. RICE: Were you associated with any hospital prior to 1950?

MR. MILLER: No.



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any hospital prior to 1950?



MR. RICE: And you always held this same position with the National Sanitarium?

MR. MILLER: Yes sir I did.

MR. RICE: I understand you have a brief to present to this Committee.

MR. MILLER: May I proceed sir?

THE CHAIRMAN: Mr. Rice would it facilitate, without interfering with the witness' presentation, would it facilitate matters if we were to have his brief taken as read and have the reporters incorporate it in the record? Would that meet with the Committee's approval?

MR. TROTTER: All right with me.

THE CHAIRMAN: Any objection to that, and this will enable you sir to then comment on the salient points which you want to bring to our attention.

MR. MILLER: I might say briefly Mr. Chairman that what I have to say initially in this brief has been adequately covered by my three predecessors who are, as you know, administrators. My position is that of the purchasing agent so of course I don't have all the figures at my disposal that they have but I do think that I know a little about the process of buying.



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SUBMISSION OF NATIONAL SANITARIUM ASSOCIATION

Appearance: Geo. E. Miller, Purchasing Agent
and Director - National Association
of Hospital Purchasing Agents

In this brief which we are today presenting for your consideration, it is not our intention to burden you with charts, graphs and statistics. We shall, however, try our humble best to give you a picture of the process evolved in the demand for, the acquisition of and the disposal of drugs and/or pharmaceuticals in our particular type of Hospital. As you probably are aware the National Sanitarium Association operates the Toronto Hospital for the Treatment of Tuberculosis, the Queen Mary Hospital for Tuberculous Children, The Gage Institute Chest Clinic along with three other permanent chest clinics in Toronto, one in Barrie, and one in Orillia. We also operate some 46 reference clinics in Ontario and until last year owned and operated Muskoka Hospital for the Treatment of Tuberculosis.

Since the sale of this particular hospital the Muskoka Hospital Memorial Research Fund, operated by our Association has come into being. I mention these facts not to impress or confuse you, but merely to indicate the nature of our particular organization as compared to the many excellent general hospitals in Metropolitan Toronto and elsewhere who deal with all manner of cases rather than specializing in any one given field of endeavour.

This is rather an important fact to



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bear in mind when attempting to form a concept of the way drugs are handled in our particular case since we do not levy any charges against the patient for drugs. In a hospital such as a General Hospital, where such charges are levied against the patient, the accounting system can be a much more complex structure than that used in T.B. Sanitoria.

As in all hospitals, the initial request or demand for any given drug or pharmaceutical used in the Chemo-therapy of a patient is initiated by the patients' physician; who would instruct the charge nurse to administer such a drug to the patient in the manner he prescribed. In our particular institutions, and since we are primarily concerned with the treatment of tuberculosis in all its phases, the bulk of the drugs used are of the anti-microbial family such as Streptomycin Sulphate, Dihydro-streptomycin, P.A.S. Sodium etc. We realize, of course, that the names of these drugs are perhaps unfamiliar to you, suffice to say that these are some of the popularly named "Wonder Drugs" which have played such an important part in reducing the death rate from T.B. in Ontario from 33.1 per 100,000 in 1938 to 2.8 per 100,000 in 1959. All Doctors in our Hospitals are on staff and we find happily for ourselves, that they are generally in accord on the usages of these drugs, which are constantly being administered to patients in large quantities. It is, therefore, essential that adequate supplies be kept on hand.



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They are supplied to our hospitals through the Ontario Department of Health, Division of Tuberculosis Prevention, by Federal Health Grant. We are not concerned directly in the purchase of these drugs and we replenish our stock by forwarding the Department's requisition form, properly filled out, direct from our pharmacist to the Department. We are not informed as to their method of purchase, but I would presume that it is competitive and by tender. Upon receipt of our requisition the drugs are supplied directly to our pharmacy and we acknowledge receipt of the particular shipment involved to the Department.

In the following few lines you will gain some indication of the quantities of anti-microbial drugs used in the Toronto Hospital for Tuberculosis during 1959:

Streptomycin Sulphate.....	52,627 Gms.
Dihydrostreptomycin.....	<u>194</u> Gms.
TOTAL	52,821 Gms.
S.C.T.P.A.S. Sodium 0.5 Gm.....	3,345,000 Tablets
C.T.P.A.S. Acid 0.5 Gm.....	48,000 "
Cachets P.A.S. Sodium 1.5 Gm....	106,000 Cachets
Effervescent Tablets P.A.S.	
2.0 Gm.....	101,200 Tablets
P.A.S. Sodium Powder.....	58 Kilo
Granules P.A.S. Calcium.....	4,000 Gms.
C.T. Calcium B-P.A.S. 1.0 Gm....	914,000 Tablets
B.C.T.P.A.S. S.A. 1.0 Gm.....	17,500 "



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In the following few lines you will gain some indication of the quantities of anti-tubercular drugs used in the Toronto Hospital for Tuberculosis during 1959:

B.C.T.P.A.S. 2.A. 1.0 Gm.....	17,500
"	
P.A.S. Sodium Powder.....	28 kilo
Effervescant Tablets P.A.S.	
G.T.P.A.S. Acid 0.5 Gm.....	48,000
"	

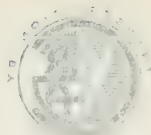


C.T. Comb. P.A.S. 0.5 Gm.	
& I.N.H. 20 mg.....	22,500 Tablets
C.T.I.N.H. 50 mg.....	1,705,000 "
Amps. I.N.H. 50 mg. Inject.....	103 amps.
C.T. Cycloserine 250 mg.....	5,025 Tablets
C.T. Pyrizinoic Acid 500 mg.....	4,500 "
C.T. Compound "377" 150 mg.....	31,500 "

Included in the amounts above the following were supplied to outpatients:

Streptomycin Sulphate.....	2,961 Gms.
Dihydrostreptomycin.....	51 "
Cycloserine 250 mg.....	740 Tablets
C.T. Compound "377" 150 mg.....	20,920 "

If you will bear with me just for a moment, and multiply the foregoing by the number of Sanatoria in the Province who receive similar assistance from the Government, you will have an idea of the tremendous amount of anti-microbial drugs used in the treatment of tuberculosis and the cost that is, of necessity, involved. Many patients continue this form of Chemo-therapy on a diminishing basis up to twenty-four months after their discharge from the hospital and the necessary drugs are dispensed from the hospital and through the Clinics to the patients until they are no longer necessary. If the patient were made responsible for the cost of the drugs used in their treatment, the financial impact, together with a loss of earning power during their illness would present a formidable



G.T. Compound P.A.S. 0.5 Gm.	
& I.N.H. 20 mg.	25,500 Tablets
G.T.I.N.H. 50 mg.	1,705,000
Apas. I.N.H. 50 mg. Inject.	103 amp.
G.T. Pyrazinolic Acid 500 mg.	4,500
G.T. Compound "377" 150 mg.	31,500

Included in the amounts above the

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Streptomycin Sulphate..... 2,981 Gms.

G.T. Compound "377" 150 mg..... 20,220

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combination of unfavourable circumstances. Fortunately through the efforts of the Department of Health, the Sanatoria in the Province and through Federal Health Grant, this situation has been almost entirely eliminated.

To the moment, we have discussed only the anti-microbial drugs we use, and to sum up briefly the sequence is as follows: The patient's doctor will require his charge nurse to have administered to the patient one or a series of drugs. If the drugs are not available in the ward medicine cabinet, they are requisitioned from the pharmacy, who will supply them from stocks on hand. If, in the case of anti-microbial drugs, they are not on hand, they are requisitioned directly from the Ontario Dept. of Health on their requisition form and, upon their order to the manufacturer, they are shipped directly to the Hospital, where they are checked by the pharmacist and receipt for same acknowledged to the Department. All other drugs dispensed in our hospitals are charged to the ward and/or department involved. In most general hospitals, I believe these charges are made against the patient.

Of necessity our hospitals must also be prepared to handle all types of hospital care and we are equipped with X-Ray - operating theatres and all the modern accoutrements of any up to date Hospital. As such, it is essential that we continue



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to operate and stock a pharmacy, under the direction of a very competent pharmacist. Such a person is a must in any accredited Hospital. His duties are to maintain and inventory his stock, fill required prescriptions, exercise precise control over narcotics and generally to fulfill the duties required of any registered pharmacist.

Narcotics are kept under lock and key and inventory control at all times. This is essential to comply with the requirements of the R.C.M.P. whose Inspector may drop in at any time without notice to check the supplies on hand.

If the nurse has been asked by the doctor to administer a drug which comes within this category, she will check her supplies which are counted each day and are kept locked away for safe keeping. If the drug is not available, she will requisition it from the pharmacist who will secure a signature from the charge nurse on the ward for the drug. A continuing record of incoming narcotics and dispensed narcotics is kept at all times.

If the pharmacist finds it necessary to replenish his stock, he forwards a requisition for the narcotics together with a special form used in the purchase of narcotics and which bears either his signature, or the signature of a Doctor. This form must accompany the official purchase order of the Hospital to the manufacturer. Without it, the manufacturer will not supply the narcotic. Other



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than this, the storage of drugs and/or pharmaceuticals presents no particular problem. Our pharmacy shelves are kept supplied as our requirements demand. All drugs, however, cannot be kept on the shelves because they may be perishable by nature. A refrigerator is, therefore, a necessity. Inventory is taken once a year and of course spot checks are taken from time to time.

For most hospitals I would suggest, and this is my personal opinion, that analysis of drugs and pharmaceuticals at the hospital would seem to be a duplication of effort. As you are aware, these drugs are all formulated under the regulations of the Canadian Food and Drug Act and are submitted to the Authorities for inspection and analysis before they can be placed on the market. I personally believe that these precautions assure the buyer of a very high and safe standard of quality. It would, therefore, seem that further analysis by the recipient would serve no useful purpose and only add further to the cost of handling. I am speaking, of course, of the normal packaged drugs. Exceptional circumstances may require other than the routine acceptance of a product and something may be gained by analysis under such conditions. If there was some question as to the ingredients, the quality or the strength of a drug, an analysis would bring to light any discrepancies and under such circumstances would be beneficial.



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You will note that in all that has been brought to your attention so far, little has been said about what happens should the pharmacist not have on his shelves or in his cabinet for narcotics the drug requisitioned by the nurse. In discussing this subject, we will disregard anti-microbial drugs which are supplied through Federal Health Grant and concern ourselves with all other drugs, as are normally used in all hospitals.

If the pharmacist is out of stock he will requisition the purchasing agent to secure the drugs required. It then becomes the responsibility of the purchasing agent to secure these drugs, at the lowest cost to his organization, considering always the quality desired, service, etc. It is his function to purchase the product, have it delivered to his Hospital pharmacy from whence it will be dispensed in its proper form to the nurse and finally the patient.

The purchase of drugs, therefore, represents for this Committee a meatier morsel to digest. At this stage, I would like to make it clearly understood that I am discussing these subjects not in my official capacity as purchasing agent for the National Sanitarium Association, but as an individual - since any opinions I might express or imply do not necessarily represent the opinions of our Association.

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ask yourself the question, "How can a layman purchase drugs; isn't this the function of a trained pharmacist?" In many instances the pharmacist does make his own purchases. This is usually true of smaller hospitals and probably true of some larger hospitals.

However, so long as a Purchasing Agent is aware of the product he is to purchase it becomes to him simply a unit. His job is to ascertain the sources of supply and buy it at the most favourable price, giving due consideration to standard of quality, etc.

I have stated previously that the request for a particular drug used in Chemo-Therapy of a patient emanates originally and initially from the tending physician. Herein lies one of the major problems facing a purchasing agent. If the doctor requests a drug by its trade name and/or citing a particular manufacturer, he immediately limits the scope of operation for the purchasing agent. If the purchasing agent is a responsible person, and I can assure you from personal contact that most of them are, he must assume that the doctor concerned has assured himself of his requirements. The purchasing agent will generally concede this and then attempt to procure the drug and/or pharmaceutical at the lowest possible price from the named company concerned. As is obvious, limiting factors are placed on the function of the



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of a patient constitutes a request and initially from
the attending physician. Hence the role of the
major problem facing a purchasing agent. If the
doctor requests a drug by its trade name and/or
offering a particular manufacturer, he immediately
limits the scope of operation for the purchasing
agent. If the purchasing agent is a responsible
person, and I can assume you from personal contact
that most of them are, he must assume that the
doctor concerned has assumed himself of his respon-
sibilities. The purchasing agent will generally concede
this and then attempt to procure the drug and/or
pharmaceutical at the lowest possible price from
the named company concerned. As is obvious, limit-

ing factors are placed on the function of the



purchasing agent. The question perhaps arises in his mind - "Should I go to the physician and ask why he prefers this product from Company "A" as compared with the product produced by Company "B" or "C". He could ask; and I believe I am in a position to tell you what kind of a reply he would get. Doctors are sometimes touchy about such things. I have conversed with physicians and surgeons now and again on such subjects over the years I have had the privilege of serving our organization and basically, their answers to such a question are simple and to the point. I have found that the reasons are generally found in the following categories:

1. They know what results to anticipate from a particular drug because they have used it successfully before.
2. His patient may be getting some side effect from the drug they would usually administer and he wishes to try another to see if he can get the same results anticipated without detrimental side effects.
3. It is a new or different drug which he has learned from his associates or from journals, periodicals, advertising brochures etc. has been proven to be of benefit in the treatment of a particular ailment, and he wishes to try it.



purchasing agent. The question arises in his mind - "Should I go to the physician and ask why he prefers this product from Company 'A' as compared with the product produced by Company 'B'?" or "C"? He would say, "I believe I am in a position to tell you what kind of a reply he would give. Doctors are sometimes foolish about such things. I have conversed with physicians and surgeons now and again on such subjects over the years. I have had the privilege of serving out of consultation and finally, their answers to such a question are simple and to the point. I have found that the reasons are generally found in the following categories:

1. They know what results to expect. They have used it successfully before.
2. His patient may be getting some side effect from the drug they would usually administer and he wishes to try another to see if he can get the same results anticipated without
3. It is a new or different drug which he has learned from his associates or from journals, periodicals, advertising brochures etc., has been proven to be of benefit in the treatment of a particular ailment, and he wishes to try it.



4. He has received samples in the mail with descriptive literature or he has been in contact with a detail man from one of the manufacturers regarding a certain drug and is anxious to try it.

All of the foregoing, we must concede, are quite valid reasons and in the face of them it would be difficult for the purchasing agent to do anything but agree with the doctor's request or requisition and procure the drug as specified. If he did otherwise, and the patient fared the worse for it, a very difficult, perhaps tragic situation might arise. So for the moment, let us assume that we have procured the aforementioned drug and it is in the category of a new or different drug than the one we have been using. What happens to the drug that the doctor was using previously for treatment? Unfortunately it is probably still sitting on the shelves in the pharmacy, outdated, obsolete, of no further use, but still representing a considerable expenditure by the Hospital.

In our particular hospital pharmacy I would estimate we have 700 to 800 different drugs and/or pharmaceuticals on our shelves and I am sure most general hospital pharmacies would surpass this number. It is essential that a sufficient variety of drugs be kept on hand to meet any emergency or requirement, but I feel that if we were fully aware



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All of the foregoing, we must concede, are quite valid reasons and in the face of them it would be difficult for the purchasing agent to do anything but agree with the doctor's request or negotiation and procure the drug as specified. If he did otherwise, and the patient faced the worse for it, a very difficult, perhaps tragic situation might arise. So for the moment, let us assume that we have procured the aforementioned drug and it is in the category of a new or different drug than the one we have been using. What happens to the drug that the doctor was using previously for treatment? Unfortunately it is probably still sitting on the shelves in the pharmacy, outdated, obsolete, of no further use, but still representing a considerable expenditure by the Hospital.

In our particular hospital pharmacy I would estimate we have 700 to 800 different drugs and/or pharmaceuticals on our shelves and I am sure most general hospital pharmacies would surpass this number. It is impossible to estimate the cost of these drugs, but it is safe to say that it is a considerable sum.

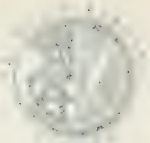


of the amount of capital tied up in partly used outdated and obsolete drugs sitting on the shelves in our pharmacies, the figure would be rather surprising. I believe, gentlemen, that serious consideration should be given to these points in your rather arduous task of investigating and interpreting the cost of drugs.

On a shelf in my office are catalogues and price lists from approximately seventy five companies. Most of them are well known in their field of endeavour with a reputation for producing fine products of proven quality under excellent conditions. Unfortunately, it becomes apparent that they are inclined to travel the same path and in their efforts to compete, we find that there are being produced many drugs of a nature so similar that I sometimes have the opinion they themselves must be confused.

In a general hospital where there may be many doctors, both on staff and otherwise, prescribing for patients this multiplicity of manufacture can only result in an increased cost factor and a well-stocked pharmacy of drugs and pharmaceuticals which if not used in their entirety, will probably sit dormant on the shelves of the pharmacy, superseded by something new or different, or become outdated and obsolete and thus have to be discarded.

It would be difficult to assume that the manufacturing companies are not aware of this



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similarity in the drugs they market. A case in point are the recent legal actions taken by some manufacturers against a competitor. Much has been said of late regarding the manufacture and sale of drugs under their generic names. The suggestion has a great deal of merit. By this, I am suggesting that if a physician asked for a drug by its generic name, it would leave the purchasing agent free to purchase the drug from any source that was free to manufacture or produce the drug under the regulations of the Act. However, let us not jump to the conclusion that this would eliminate the possibility of one company changing the qualities or formula of a given product and marketing it under its new generic name. And may I humbly suggest that if the Government permits the import of drugs under their generic names from foreign countries; facilities should be made available to assure the people of this country that the quality of the product entering the country is equal to or better than domestic products.

No doubt you will be interested in the actual cost of drugs to Hospital. Have prices been rising steadily as has been suggested on many occasions or have they decreased? My impression had been, I must candidly admit, that the cost of drugs has been increasing over the past ten years, along with very near everything else we purchase. To answer my own question, I chose from my



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I chose from my



catalogues the price lists of a Company I thought was fairly representative and examined their last three price lists. Further I chose a drug, at random, from each successive page, being selective only to the point where I felt I had covered every type of drug and package from tablets, to injections, to suppositories to narcotics. The foregoing does not by any means cover all the drugs manufactured by this Company, but is a fair cross section:

-

(List of Price Changes follows)

-

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-

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ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Price Changes as exemplified by price lists of Company "X"

Miller

in a period of three years - 52 days

2190

* NARCOTIC

NOV. 15/57 MAY 7/59 JAN. 6/61

INCREASE
(IF ANY)

DRUG	PACKAGE	LIST PRICE	LIST PRICE	LIST PRICE	
A	1 cc vials each	.98	.99	.99	.01
B	Troches per M	9.85	9.95	9.95	.10 per M
C	2 oz. Tube each	2.20	2.20	2.20	NIL
D	4 oz. Tube each	10.50	10.60	10.60	.10 ea.
E	1 gal. Bottles each	36.70	37.05	37.05	.35 ea.
F	50 mg. Ampoules 1 cc per c	64.70	65.30	65.30	.60 per C
G	Tablets - per M	146.20	147.55	147.55	1.35 per M
H	Capsules per M	55.90	56.45	56.45	.55 per M
I	Ampoules - per C	138.60	139.85	139.85	1.25 per C
J	50 mg. Tablets per C	4.60	4.65	4.65	.05 per C
K	Tablets - per M	43.10	43.50	43.50	.40 per M
L	$\frac{1}{2}$ oz. Tubes - each	2.75	2.80	2.40	.35 ea. (Decrease)
M	Capsules - per 500	17.80	18.00	18.00	.20 per 500
N	Tablets - per M	2.50	2.50	2.50	NIL
O	Tablets - per 500	41.25	41.60	41.60	.35 per 500
P	20 cc Vials - Box of 25	9.50	9.60	9.60	.10 box of 25
Q	30 cc bottles - each	9.95	9.95	9.95	NIL
R	1 gal. Bottle - each	43.30	43.70	43.70	.40 per gal.
S	Tablets - Per 500	39.60	39.95	39.95	.35 per 500
T	Suppositories - per C	17.30	17.45	17.45	.15 per C
U	$\frac{1}{8}$ gr. Tablets per M	45.05	45.45	45.45	.40 per M
V	Tablets - per M	108.90	108.90	108.90	NIL
W	10 Dose Vial - each	1.83	1.85	Disc.	.02 ea.
X	0.5 gm. Ampoules - Box of	26.50	26.75	26.75	.25 box of 25
Y	10 gm. Container ea.	11.00	11.10	11.10	.10 ea.
Z	Vials - Complete set	12.45	12.55	12.55	.10 set



ANGUS STEINHOFF & CO. LTD.
TORONTO, ONTARIO

	Africa - Composites each	15.12	15.22	15.22	10 set
A	10 box Composites each	11.00	11.10	11.10	10 set
X	0.2 box Composites - box of	50.20	50.42	50.42	52 box of 52
M	10 box Africa - each	1.63	1.82	1.82	52 set
A	10 box Africa - each	100.20	100.60	100.60	100 box M
U	1 1/2 box Composites box M	12.02	12.12	12.12	12 box C
L	Composites - box C	11.20	11.12	11.12	12 box C
S	10 box Africa - each	30.20	30.32	30.32	30 box 52
W	1 box Africa - each	13.30	13.20	13.20	10 box 52
C	30 box Africa - each	8.32	8.32	8.32	10 box 52
B	50 box Africa - box of 52	8.20	8.20	8.20	10 box 52
O	10 box Africa - box of 52	11.22	11.20	11.20	10 box 52
N	10 box Africa - box M	5.20	5.20	5.20	10 box 52
M	Composites - box 200	11.80	18.00	18.00	30 box 200 (Peonies)
I	1 1/2 box Africa - each	5.22	5.20	5.10	32 set
K	10 box Africa - box M	13.10	13.20	13.20	10 box M
Q	20 box Africa - box C	1.60	1.62	1.62	10 box C
L	Composites - box C	13.60	13.62	13.62	12 box C
H	Composites box M	22.20	22.12	22.12	12 box M
O	10 box Africa - box M	11.20	11.22	11.22	12 box M
E	20 box Africa - box C	11.20	11.22	11.22	12 box C
D	1 1/2 box Africa - each	31.10	31.10	31.10	32 set
C	1 1/2 box Africa - each	10.20	10.20	10.20	10 set
B	50 box Africa - each	5.20	5.20	5.20	10 box M
A	10 box Africa - each	8.22	8.22	8.22	10 box M
	10 box Africa each	8.22	8.22	8.22	10 box M

* SPECIFIC

100.12/12 100.12/12 100.12/12 100.12/12
(10.12/12) 100.12/12

in a period of 100 years - 25 years

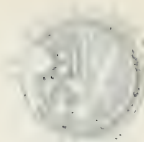
These numbers are calculated by the office of the United States
WITNESSES



All prices noted above are list prices and are subject to the usual discount of 40% to Hospitals. Further, sales tax may be deducted if the purchasing Hospital certifies its purchase orders as being exempt.

In order to be fair, and I am sure that is our intention, we must concede that the foregoing figures indicate little if any increase over the past three years and in most instances, no changes since May 7th, 1959. This would seem to indicate a levelling off of prices because of the general state of business, or a reluctance to bask in the limelight of public opinion. In all fairness we must be thankful for the wonderful and costly research laboratories from whence emanate these marvellous remedies. Admittedly these laboratories are costly to set up, to staff, and to operate, and in assessing the situation as it exists today we should consider these points. But, if we are to consider these points, we must also consider whether or not there is a need for the very costly publications, brochures, advertising, packaging and sampling which also emanates from these sources in a steady flow, the cost of which inevitably is paid for by the consumer. However, it has been encouraging to note in recent months a few decreases in the cost of some drugs.

To summarize the foregoing, may I say this: With the ever increasing costs



975949.



Hospitals are subjected to in every field of operations, the cost of drugs added to the cost of handling, storing and administering them to patients, through the hospital pharmacy, etc. is a very real and important factor. If, on the other hand we feel the cost of drugs is unnecessarily high and that by introducing the sale of drugs by their generic name will, because of the lesser cost of imported brands, open the market up to more competition thereby having the effect of forcing prices down; then in my humble opinion we should ask our Government to assure us that the quality of the imported drugs should measure up in every way to the quality of all other drugs available in Canada. They should be checked as carefully and if any cost for this service is involved, it should be assessed against the exporter or importer before they are placed on the market in Canada. This, I feel, is the only way we may buy in confidence and I believe it is only fair to have the whole industry competing on the same basis.

It is, therefore, desirable and it is our sincere hope that the drug industry, through a realistic, re-appraisal of their cost and the ultimate cost to the consumer, whether it be a hospital or otherwise, will find it possible to introduce further reductions in



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ANGUS, STONEHOUSE & CO. LTD.
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Miller

2193

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THE CHAIRMAN: Would you like to tell us just a little bit about the scope of the operation of the Association you represent?

MR. MILLER: Well we sir operate the Toronto Hospital for Tuberculosis, and the Queen Mary Hospital which combined are approximately 656 beds. The Davis Cottage Hospital we have no further use for as all tubercular children are sent to the General Hospital, initially.

We also operate the Gage Institute Chest Clinic which is pretty well known. We have three other permanent clinics in Toronto, one in Barrie and one in Orillia and we operate 46 reference clinics in this part of Ontario together with the Muskoka Hospital Memorial Research Fund which was evolved after the sale of the Muskoka Sanitarium to the Provincial Government last June and my particular position, I am in complete charge of purchasing for everything that is bought under their name.

MR. WHITE: How many beds do you buy for?

MR. MILLER: At the moment sir we are buying for about 656 beds in all, and at the moment we are renovating and preparing to take in chronic cases. We will have, I hope, by the end of August perhaps 70 beds available.

MR. WHITE: That is chronic tubercular cases?



THE CHAIRMAN: Would you like to tell

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MR. MILLER: That is apart from tubercular cases. As you probably know we are incorporated as an Act under the Federal Government and National Sanitarium Act which was amended I believe last year to permit us to handle general hospital cases.

MR. BOYER: Most of your drugs are supplied through the Ontario Department of Health?

MR. MILLER: That is a good question sir. Actually the bulk of the corrective drugs that are used in the Chemo-Therapy of patients is supplied by the Provincial Government, provided through the Provincial Government by Federal health grant. On page 3 of that brief you will see, for your information, the enormous amount of drugs that are used in curing tuberculosis. I think it is only fair to point out that through the use of these drugs we reduced the death rate from T.B. in Ontario from 33.1 per 100,000 in 1938 to 2.8 per 100,000 in 1959.

I think this is a record we can all be very well proud of. You will note on page 3 there the S.C.T.P.A.S. which is of course, sugar coated tablets P.A.S. Sodium 0.5 Gm 3,345,000 tablets; a little further down there is C.T.I.N.H. 1,705,000 tablets. If the cost of these drugs was to be borne by the people who are patients suffering from T.B. together with their loss of earning power it would present a pretty tragic picture. Most of them would be unbearable.

MR. FULLERTON: Have you any idea



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would be undesirable.

MR. FULLERTON: Have you any ideas



what these figures would represent in dollars and cents?

MR. MILLER: I haven't sir, because I have no direct connection with the purchase of these particular drugs. I know it to be a rather fabulous figure when multiplied by the number of sanatoria in the Province who are obtaining this same relief through the federal grants that we are. It would be a terrific figure.

MR. BOYER: Mr. Chairman, I might point out there was previous evidence about the purchasing of such drugs as P.A.S. and Streptomycin. They were very expensive drugs when first brought on the market. It may be it is necessary for the hospital to supply them. I think the cost of those drugs today is very, very much lower.

MR. MILLER: It is, but it is still considerable and this of course is true of all more or less of the wonder drugs when they are first produced and put on the market they are very, very expensive and as they come into production they are reduced in some cases considerably in cost.

MR. BOYER: Mr. Miller you have clinics around this section of the Province?

MR. MILLER: That is true.

MR. BOYER: You have out-patients I think?

MR. MILLER: That is right.

MR. BOYER: Do you supply them with



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MR. HOYER: Do you supply them with



drugs?

MR. MILLER: They are supplied with drugs through the clinics.

MR. BOYER: Free are they?

MR. MILLER: Free, that is correct, sir; I would say up to about 24 months progressively reduced basis depending, of course, upon the condition of the patient but there is more out-patient treatment of tuberculosis in recent years than there has been because of the nature of these particular drugs.

MR. FULLERTON: I wonder if we could get a figure on these tablets for this year's purchase?

MR. MILLER: Yes, I think that could be arranged. We can produce it for your secretary Mr. Chairman, if you wish me to.

MR. FULLERTON: If we could get this for the record as to the cost both wholesale and retail, cost to government and what the price would represent on a retail basis.



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2197

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AG/hm

MR. MILLER: I will try to cover that to the best of my ability. I think I could procure those figures through the invoices to the government.

MR. RICE: Perhaps since you are a purchasing agent you could explain to the committee how you go about purchasing these drugs?

MR. MILLER: Of course, to a purchasing agent a drug is like anything else a tumbler, a desk or anything else. We are asked for a unit. If we are asked for an Abbott product, or an Ayerst product, which represents a unit, we go to that particular company for this unit, provided all things are equal.

MR. RICE: Are the requisitions to you in that form? Do they request a specific manufacturer?

MR. MILLER: I would say yes to that question. There may be some deviation, but in most cases you are asked for a particular drug. This is the emanation of the demand, or request from the patient's physician, and a doctor is just like any of the rest of us. You get used to using a certain tool and he does too. If he is used to a product by Ayerst, why should he take a chance and use a product by Lederle. It is not because a doctor wants to be demanding. It is easier for him to do it that way. Three of us might go to the hardware store and pick out a saw. To all intents and purposes it is the same saw, but to each of us it



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has a different feel.

MR. RICE: When you go to buy these drugs designated by manufacturers, do you get tenders?

MR. MILLER: Of course the bulk of our tablets are purchased by the Federal Government or by the Provincial Government, and in quantities like that it would be folly not to call for tenders, but you must remember in the treatment of most general cases the demand for a drug is limited by the extent of the patient's illness, so you might get product A demanded by the doctor, and the patient is on it for six weeks and is cured, and you have two weeks supply left.

MR. WHITE: Do you get these drugs from the government or from the supplier?

MR. MILLER: These drugs are requisitioned, we requisition these drugs, our pharmacist does, because we keep a large quantity on hand. He requisitions them on the Department form to the Department of Health, who in turn have them shipped directly to us from the manufacturer.

MR. WHITE: So you don't buy them?

MR. MILLER: We don't buy them at all, not at the moment. We may be going to have to.

MR. WHITE: They just requisition what they need?

MR. MILLER: This only concerns these wonder drugs that we are using primarily for the



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treatment of tuberculosis, but you must realize we have a full-time doctor on all the time.

THE CHAIRMAN: Mr. White, you might want to develop that a little bit and find out what the purchasing power is of his organization in dollars.

MR. WHITE: What do you spend on drugs, other than the ones supplied by the government?

MR. MILLER: I cannot offhand say. I have an idea, but I would hesitate to guess. You see, our costs are charged to the wards, to the departments, they are not charged to the patients as such.

MR. WHITE: Is it a thousand dollars or ten thousand?

MR. MILLER: I would think that in the course of a year our cost of drugs would probably be up around \$18,000.00 or \$20,000.00. I am hazarding this as a guess. I could provide the information.

MR. WHITE: In addition to these drugs you get without charge?

MR. MILLER: Yes, I think that would be a reasonable estimate. I can be specific if that information is desired.

MR. RICE: Could you tell us at what discount you are able to purchase these drugs?

MR. MILLER: I don't think there is any secret about this. Most manufacturing producers of



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drugs have a standard discount which amounts to large buyers such as ourselves to 40%, and you sometimes hear the discount 50%, but I believe this is in lieu of the additional sales tax which you might be exempt from. In other words, instead of 40% off plus sales tax, you get 50%.

MR. RICE: In your experience in purchasing, do you get 50 or 40?

MR. MILLER: This is simply the policy of the company involved, it is not consistent.

THE CHAIRMAN: Mr. Rice, I think you might develop the question with the witness as to the noticeable or apparent lowering of prices of drugs in his experience in the last year.

MR. RICE: In your purchasing in the last year, have you noticed the change in the price of some of these drugs?

MR. MILLER: On page 10 of this brief you will see a list of drugs from A to Z. I might just read a paragraph of this.

No doubt you will be interested in the actual cost of drugs to hospitals. Have prices been rising steadily as has been suggested on many occasions or have they decreased? My impression had been, I must candidly admit, that the cost of drugs had been increasing over the past ten years, along with very near everything else we purchase. To answer my own question, I chose from my catalogues the price list of a company I thought was fairly

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representative and examined their last three price lists. Further I chose a drug, at random, from each successive page, being selective only to the point where I felt I had covered every type of drug and package from tablets, to injections, to suppositories to narcotics. The foregoing does not by any means cover all the drugs manufactured by the company, but is a fair cross-section.

If you will look at those drugs, you will see that there were some slight increases from November the 15th 1957 to May the 7th 1959 in practically all of them, and from May the 7th to January the 6th practically no increase. This would seem to indicate to me that it is either because of static business difficulties, or the drug concerns do not want to bask in the limelight of public opinion. It would seem to indicate actually that in the past three years there has not been much increase, but this does not change my opinion that drug prices have been high over a period of years.

THE CHAIRMAN: Have you seen any reduction in prices in the last twelve months?

MR. MILLER: There has been some indication of price reduction, but today I discovered not only a price reduction but a price increase. I have in my bag a product manufactured by a company which we have been buying for \$34.00 a thousand. It is manufactured in the United States, and they are using a product in it which is



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manufactured by a well-known company in Canada. I have been approached in the past week by the company in Canada, which has started to produce the same thing only stronger at \$21.34 a thousand. That is quite a price reduction, and is indicative of perhaps what the industry can do if they nail things down.

On the other hand, I have checked the price of a certain product which was a vitamin pill. As a matter of fact I took some myself, but they didn't do much but give me heartburn so I discontinued. We purchased them for \$8.50 a thousand in the last ten years, and this year they went up to \$10.80 a thousand.

MR. RICE: How do you charge for prescriptions?

MR. MILLER: We don't. There are no charges against patients at all.

MR. RICE: Are there any sales of drugs to people who are not out-patients?

MR. MILLER: Not to my knowledge.

MR. WHITE: Except for out-patient clinics?

MR. MILLER: They are provided drugs free, because they are of course provided free to us.

MR. WHITE: What about the ones you buy, do you give them away?

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MR. WHITE: Do you agree with the last speaker that there might be some danger in having a public analyst?

MR. MILLER: I fail to see the need for a hospital purchasing drugs produced under the Canada Food and Drugs Act to add that additional cost to their handling of drugs. There might be an exceptional instance in a hospital where a doctor is unsure of a certain drug and wants to prove to himself that it is correct, and might send it over to our lab, but if this took place in all cases we would be snowed under.

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MR. MILLER: It is supposed to.

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samples, or close to it, but do it on a random basis. They do not necessarily inspect premises.

MR. MILLER: I saw a movie produced by the National Film Board entitled "By Prescription Only". It might be useful for the Committee if they found time to see it. It is only a 20 minute run. In that it is stated that they do check all of these prescriptions before they are produced in volume and marketed.

MR. BRYDEN: Oh, yes, but there is no guarantee of the quality of any batch of a particular drug that comes onto the market. I notice in your brief that you make a point, and quite properly, that we should be sure that all drugs are of the quality called for.

MR. MILLER: Most of the reputable companies, the well-known companies, I think have a standard that they maintain in their product, and have a lab for this particular purpose. I think this is done mostly in the larger concerns. You are talking about the immediate quality of the drugs that come from the producers. The Canada Food and Drug Act says you can produce this drug but from there on it is a question of whether Lederle's are going to maintain the quality. We send inspectors into the meat plants, so why not send them into the drug plants?

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MR. MILLER: We had an experience in our drugs. They were purchased for us by the Department. It is a little amusing. We had some 25,000 of these things and these pills were so good that they never did dissolve in the patients, and we had to send them all back. This is just to illustrate the standards of quality. A pill is a pill is a pill, and goldarn it, it is supposed to do something.

MR. RICE: Has your association a formulary?

MR. MILLER: No, we have a very experienced and competent and old-time pharmacist, who has been with us for years, and he is supervised by the assistant superintendent of the hospital, who is a very eminent, as a matter of fact one of the best in the world, chest surgeon and a physician, and he keeps control of the pharmacy. Any drug that is added to our pharmacy is done with his approval.



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MR. MILLER: You must remember the doctors in our hospital are staff doctors, more or less of a permanent nature. They are not temporary doctors coming and going, on and off staff. We have had the same group for several years, and we have added to it now and again, but for all intents and purposes, they are long-time employees so that there is more, shall we shall, congeniality amongst the doctors themselves as to what drugs they can use for the treatment of tuberculosis.

MR. RICE: Is there any system of substitution or is there any question of substitution?

MR. MILLER: This doesn't come up too often. If there was, I think it would be left to the ability of our pharmacists, whom, as I say, have been with us a great many years, and have the full confidence of our superintendent and assistant superintendent.

MR. RICE: When you purchase from wholesalers, do you get somewhat the same discount as you do from manufacturers?

MR. MILLER: Well, I presume you mean in the sense of distributors? Most of these distributors are protected by the manufacturers. There may be variances, depending on how fortunate you were at the time. You might buy a drug at 40% from the manufacturer, and it might cost you 45% from the distributor.



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On the other hand, it may be just reversed. The manufacturer would say "Here I have this distributor and I want to give this fellow 35% so he will go to my distributor and buy it", so they protect themselves in that particular.

MR. RICE: Mr. Chairman, are there any other questions?

THE CHAIRMAN: Mr. White? Mr. Bryden? Mr. Price? Mr. Trotter?

MR. TROTTER: No questions.

THE CHAIRMAN: May I tell you, Mr. Miller, that we appreciate you coming down here, and we understand the importance of your National Sanitarium Association with respect to the treatment of this particular disease, and the good job that you are doing. We only learn here on the Committee from people like you who come along and talk in a forthright manner such as you have done today, and we thank you.

MR. MILLER: Thank you very much, sir.

MR. RICE: That concludes the witnesses for this afternoon, Mr. Chairman.

THE CHAIRMAN: I am just wondering when we are arranging future meetings if four witnesses are not too many. Have you any comments on that, Mr. Wren?

MR. WREN: I would think so. It affords some embarrassment to people who come a distance and then don't get on that day.

THE CHAIRMAN: We have heard everyone



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today, but I think it is a little heavy going, isn't it, Mr. Gadsby?

MR. GADSBY: From what we have experienced, sir.

THE CHAIRMAN: There are two sides to the coin. Firstly, we want to hear all these people, and on the other hand we don't want to wear them out waiting and so on. Now, have you any comment about the hour, Mr. Trotter?

MR. TROTTER: Possibly if we start earlier, it might be a bit better.

THE CHAIRMAN: Two o'clock?

MR. TROTTER: Two o'clock is fine with me.

THE CHAIRMAN: Does that meet with your approval, Mr. Bryden?

MR. BRYDEN: If it makes no difference to you, I am afraid I can't come in any event.

THE CHAIRMAN: We will miss you.

MR. WHITE: I can't come either, Mr. Chairman. I hope you will miss me too.

MR. BRYDEN: You might get more witnesses through without inviting me.

THE CHAIRMAN: Shall we say two o'clock tomorrow, and I have a matter which will involve my attention tomorrow afternoon, and I will ask Mr. Whitney if he will carry on.

MR. WHITNEY: Will we have a quorum?

MR. WREN: What is a quorum, five?



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tomorrow, and I have a matter which will involve my

attention tomorrow afternoon, and I will ask Mr.

Whitney if he will carry on.

MR. WHITNEY: Will we have a program?

MR. WREN: What is a program, five?



MR. TROTTER: Six is a quorum.

THE CHAIRMAN: Will you carry on, Mr.

Whitney?

MR. WHITNEY: Yes.

THE CHAIRMAN: And we will adjourn until
two o'clock tomorrow.

MR. GADSBY: There will be a quorum
tomorrow?

THE CHAIRMAN: Mr. Trotter, will you be
here?

MR. TROTTER: Yes.

MR. BOYER: I had thought I would be late.

MR. BRYDEN: I thought you suggested two
o'clock.

MR. BOYER: I kept very quiet.

THE CHAIRMAN: Mr. Wren is five and Mr. Price
is six and Mr. White?

MR. WHITE: I am speaking in London
tomorrow.

MR. PRICE: Is six a quorum?

MR. WHITE: The suggestion has been made
that this full Committee might name a sub-committee to
take these briefs tomorrow even though there are only
four or five people -- from a parliamentary point of
view.

THE CHAIRMAN: Shall we authorize, by
resolution authorize Mr. Whitney to carry on and
hear the presentations of the four medical men tomorrow
regardless of who else may be present?



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Miller

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MR. BRYDEN: I will so move.

MR. TROTTER: I will second the motion.

THE CHAIRMAN: Are there any objections to that? Well then, Mr. Whitney, will you carry on and the Committee will proceed under those terms of reference?

---Whereupon the hearing is adjourned at 5.45 p.m.



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--Whereupon the hearing is adjourned at 2.45 p.m.

Select Committee on Drugs

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HELD AT

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TORONTO ONTARIO

VOLUME No.:

22

DATE:

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SELECT COMMITTEE ON DRUGS

Proceedings of hearings
held at Parliament Buildings,
Toronto, Ontario, on Wednesday,
the 14th of June, 1961,
at 2.10 p.m.

COMMITTEE:

MR. H.L. ROWNTREE, Q.C. -- Chairman
MR. N. WHITNEY -- Acting
 Chairman

MR. A. WREN
MR. J.A. FULLERTON
MR. J. TROTTER
MR. R.E. SUTTON
MR. R.J. BOYER
MR. H.J. PRICE
MR. K. BRYDEN
MR. J. WHITE
MR. G.F. LAVERGNE

MR. S.J. GADSBY, F.C.I.S., Secretary
MR. HAROLD A. RICE -- Committee Counsel
MR. W.J. AYERS -- Accounting
 Consultant to the
 Committee



B./dpw

--- On resuming at 2.10 p.m.

THE CHAIRMAN: Gentlemen, as you know, our Chairman is unable to be with us today.

The meeting will now come to order. I understand that Dr. Fallis is here. We hope that other members of the Committee will be able to join us later. I would like to ask Dr. Fallis to step forward. Mr. Rice, if you will please start off.

MR. RICE: For the purpose of the record, doctor, would you tell us your full name?

DR. FALLIS: Frederick Brewster Fallis.

MR. RICE: I understand you are a licensed medical practitioner?

DR. FALLIS: Yes, that is correct. I am in general practice in North Toronto.

MR. RICE: Whereabouts in North Toronto do you carry on practice?

DR. FALLIS: Avenue Road and Wilson.

MR. RICE: When did you graduate?

DR. FALLIS: 1953.

MR. RICE: And from what university?

DR. FALLIS: Toronto.

MR. RICE: After graduation did you do any post-graduate work?

DR. FALLIS: Just the standard one-year junior internship, and launched into practice after that.

MR. RICE: And have you always practised



at the same address?

DR. FALLIS: Yes, the same address.

MR. RICE: Have you any prepared statement you would like to make to the Committee on the subject matter?

DR. FALLIS: No. I was requested to come down and answer any questions the Committee might have and help in any way I could, give background information.

MR. RICE: Thank you, doctor. In your profession do you have occasion to prescribe drugs in the type of practice you carry on?

DR. FALLIS: Yes. I do an active city type of practice, and there would be several prescriptions to write every day, sometimes a great many. I also go to the Toronto General Hospital medical outdoor two mornings a week and prescribe there, and I also happen to work a couple of times a week at the Alcoholism and Drug Addiction Research Foundation, which is a provincially-sponsored foundation, and there again we dispense, we prescribe drugs there and dispense.

MR. RICE: Can you give us any approximate number of prescriptions you would write in a year?

DR. FALLIS: Well, it would only be a guess, but I would think it might run to six or eight a day, and I suppose I might be working something like 300 days a year, so it might run between



at the same address.

DR. FALLIS: Yes, the same address.

MR. RIGB: Have you any other statements?

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1,500 and 2,000, something like that.

MR. RICE: Do you find the number of prescriptions in your practice on the increase, are you prescribing more and more?

DR. FALLIS: No, I don't think so. I think that perhaps as I go along I tend to rely more on the standard medications, perhaps half-a-dozen or a dozen medications that are more or less standard, and these look after the vast majority. Of course, these are in different forms, they are not all pills and capsules; there are liquid preparations for children, there are local applications for eye and skin and injectables, and so on.

MR. RICE: Do you dispense any of the drugs you prescribe?

DR. FALLIS: No, I don't. But if people come in - of course, the injectables in a sense you dispense them when you inject them into the patient. Other standard things one always carries in the bag or in the office, standard things for relief, pain, and so on, where a person comes in with an acute shoulder or back, and I think most doctors would have them on hand. I think most doctors have many samples that are left, and sometimes these are given to the patient immediately to start them off.

MR. RICE: Can you give us any approximation as to the value of drugs that you have on hand in your own practice?

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MR. RICE: Do you think the number of

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MR. RICE: Can you give us any approxi-

mation as to the value of drugs that you have on

hand in your own practice?



DR. FALLIS: You mean in the cupboard,
in the bag?

MR. RICE: Yes.

DR. FALLIS: Oh, it is not very great.
I would think under \$25. I would think so. I don't
know.

MR. RICE: Where do you obtain these
drugs other than samples?

DR. FALLIS: Well, most of them are
obtained from the same place where we get other
office supplies, such as pads, minor dressings, and
so on, where we happen to go to the drug houses down
the road, for codeine and things like that. Other
things such as gammaglobin, which is given for
measles, and so on, at times these are available free
from the Red Cross. Other times when their stocks
are short it has to be paid for, and if it is going
to go stale quickly we might get it from the local
pharmacy.

MR. RICE: When you purchase drugs from
the drug supply house, is there any particular
discount?

DR. FALLIS: I really don't pay much
attention to that. I know we get aspirin, caffeine
and codeine - for example, the 222 has an eighth of a
grain. We keep a bottle, a thousand of the quarter
grain and a thousand of the eighth grain, depending
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deal cheaper, but I don't think there would be any particular discount than there would be on any other surgical supplies. I think they encourage you to pay cash, with 5% discount for cash, which is normal business practice.

MR. RICE: I understand most manufacturers have a list price for their drugs and that retailers, and so on, buy them with a discount off the suggested list price.

DR. FALLIS: Yes. I am sure if we were to buy these things from Frosst, for example, directly from a chemical house, there would be a rate, but it is not a big concern to us. I suppose we could run into that, where we would be getting things from the local pharmacy, he would have a price for drugs sold to doctors. I don't know what it would be. One would have to ask the pharmacists.

MR. RICE: I don't think those supply houses would have much sale to the public. I suppose one could go down, say, to a company and buy aspirin over the counter, and I can't say whether we would be getting it at very much less than a patient would. I can't tell you. If you went in for a thousand aspirin I don't know whether you would get it at anything different from what I would.

MR. RICE: And the local retail store, have you discussed price with them, discount?



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DR. FALLIS: No, I don't know, I don't know. I think it might vary from drug to drug depending on how much room he has to manoeuvre but I know that I have gone in myself and bought some things, if I am in a hurry, and I would get the impression that there would be something like perhaps 30% off or 40% off, something like that.

MR. RICE: When you purchase from the retail stores do you usually purchase from the same store all the time?

DR. FALLIS: Yes, we usually do but we make no effort, on the other hand, to -- I think this is a point in which one has to be scrupulously careful because I think this is important that the patient have complete freedom of action where he goes to get his drugs just as he should have freedom of action in what doctor he consults and we don't put any -- we wouldn't use a dispensing pad, for example, with a druggist's advertisement on the bottom and we don't direct the patient in any way as to where they should go.

MR. RICE: But you yourself -- I notice you are using "we" through here. Are you speaking for the profession or is there some associate in practise with you?

DR. FALLIS: I have a partner who practises with me. This is a loose partnership. We have completely separate practises and books, nurses are separate, staff, phone, but certain



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things that we stock in the office we buy together simply because it is more economical to do so.

MR. RICE: But when you purchase these drugs for your own use, that is for your office use do you usually cater to the one retail store?

DR. FALLIS: Yes, we do which I think is perfectly within our province. I think we should be allowed to go where we wish.

MR. RICE: I just want to follow that up.

DR. FALLIS: There is no reason why we do except that he is nearby and he happens to be running a prescription pharmacy. He has a couple of stores and we buy from the retail that he has which is for prescriptions only. There isn't a lot of other stuff there. We think it is a very neat place to do business, you know.

MR. RICE: This 30 to 40% discount you usually get, that is from that particular pharmacist?

DR. FALLIS: Oh yes, but we often buy drugs from two other drug stores which are down from us and be roughly the same. I think this would all be fairly well set down from their point of view. I think that any doctor who came in and asked for something, as a matter of professional courtesy that is done.

MR. RICE: Well have you any pre-arrangement with him whereby they agree to give



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you a certain discount on your purchases from him?

DR. FALLIS: No, in fact sometimes I go into some of the stores on the street where they don't recognize me and just for the fun of it I just buy across the counter. It can be a little tiresome at times, you know, they insisting on reducing this on some very minor item but I think if they know that you are a doctor that they have a certain price that they would give to a doctor for drugs that he is using in his practice.

MR. SUTTON : There is no definite per cent is there? Yesterday we heard from two or three smaller hospitals and they said it is pretty uniform that they got 40% off on the manufacturer and 25% off when they bought from the local drug store.

DR. FALLIS: Those figures would sound reasonable to me and I am sure if one called up the local pharmacy he would say well for most drugs it is such and such a figure. I just have never asked them, that's all.

MR. RICE: What is the usual range, this is the retail range, the price of your prescriptions?

DR. FALLIS: Oh I would think that it would vary from a couple of dollars up to -- these are common things -- up to \$12.00 or \$15.00 occasionally for say a five or six day supply of a drug that I had bought for a standard four



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capsule a day dosage; would run into that neighbourhood. If you had pneumonia or something and you thought it should be treated for six days instead of three or four.

MR. RICE: On these drugs that you dispense yourself, in the sense that you said it was injectables that you occasionally give your patient, how do you charge the patient for those drugs?

DR. FALLIS: Well usually if it's an injectable I think it's a fairly common practise to add one dollar to the cost of the house visit which at present at Toronto is \$5.00 for a daytime visit. If the patient receives an injection of penicillin in addition I usually put \$1.00 on the bill.

MR. RICE: What would that injection of penicillin cost you, that is for the drug?

DR. FALLIS: I think in the neighbourhood of between say thirty and fifty cents. Something like that. The O.M.H.A. schedule of fees, not counting the cost of injectable, just performing the service, you have to have a sterile syringe there with a sterile needle, have to be pulled up without air and put in properly, the charge if a person is going in there for the sole purpose of receiving injections for hay fever and penicillin it's \$2.00 plus the cost of the injectable so as a rough rule of thumb that seems

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to work out quite well. I think that's common practise.

MR. RICE: When you charge that , plus the cost of injectable, what cost is that? The cost to you or the manufacturer?

DR. FALLIS: No, we don't add the cost of the injectable. We just put one dollar on the bill and that's that. The only thing we would calculate the actual cost of the injectable is in something that is quite expensive and I can think of two that are. One is gammaglobin in which I mentioned before. I have forgotten the exact cost of that but it's in the order of about \$1.00 a cc. This would really sting if you didn't pay any attention to it and the other is the injection given quite commonly nowadays into rheumatic or arthritic joints or tissues of hydro cortisone, or cortisone derivatives and they again run quite often over \$1.00 a cc.

Our practise happens to be to charge that exactly as the cost to us. If we have paid \$1.50 for a cc of cortisone that is what we add to the cost. The service allowance in the O.M.H.A. schedule of fees for injecting into the joints is usually five.

MR. RICE: When you prescribe your drug do you prescribe under the generic name or under a trade name?

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deal. I think that in some common drugs I use the generic name. Penicillin I usually prescribe in tablet form by generic name and this is one of the commonest prescriptions we have.

The A.P.C. of C. mixture for relief of pain I would usually prescribe by generic name. I use the generic name where I can, providing that I think there is no advantage to using the other name. Some of the generic names, as you may know, are really tongue twisters. You know they are a little side chains on side chains and this and that hydroxy and it is difficult to learn the generic name but we can do that if we needed to.

I think the answer is that I use the generic name where I can. There are some other drugs where I don't. Tetracycline is another one where I would use the generic name.



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Chloromycetin usually. I think there are some drugs that one does not use the generic name, because one has the impression that there have been types of this drug come on the market that perhaps were not up to standard, and --

MR. RICE: When you prescribe by the generic name, do you leave it up to the druggist then as to what manufacturer he will select?

DR. FALLIS: Oh, yes. That is what happens I believe when you prescribe by generic name. The druggist is legally entitled to prescribe any good sample of that drug.

MR. RICE: When you prescribe, do you ever suggest substitutes to the druggist if he has not got what you prescribe?

DR. FALLIS: Oh, very rarely. I would sometimes agree to a substitute if he called up, but I think if one made the point that ten or twelve drugs are repeated over and over and over again, really it is not a big list of a hundred that one is using all the time, it is a basic list, and well, every druggist has them.

I feel strongly that we don't hear enough about the service that the druggist supplies the community in Canada as a second man who is checking on that prescription, who is recording the number of the prescriptions in case two years from now, if the doctor were dead, it would help the patient a lot, another doctor could 'phone there and



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immediately find out what it was the patient had, and again by using his judgment, if I use a generic name for a drug, you say can he dispense anything he wants, well, sure, he can, but this is another part of his service. He uses his judgment and makes sure there is decent quality control on this.

I feel that we are not buying tablets or capsules from the druggist. I feel the service aspect of his fee is very important, and is not too well understood by patients on the whole.

MR. RICE: Do you receive complaints from patients sometimes then about the cost they have to pay for drugs?

DR. FALLIS: Certainly I do, yes. Now, I am practising in a residential district, which, well you are familiar with the district. It is a middle-class district I might say. There are not a great many complaints of a serious nature. In that district they are mostly sort of good-natured irritation, and at times I will take time to explain the service aspect of a prescription that I have just mentioned, and other things, such as the fact of a \$16.00 prescription being used over 8 days. That is \$2.00 per day, and on a cost per dose basis this is not great. These explanations are often appreciated.

MR. RICE: Do you find then that is probably where some of the difficulty lies with regard to patients, that they don't understand what they are paying for?



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DR. FALLIS: Oh, yes, and I think that what the doctor wants in a drug he wants it dispensed at as reasonable a cost as possible. But the possible meaning that to my way of thinking that the patient has a choice of druggists, that he can go to any druggist he wishes, and that way don't sacrifice the legitimate claims for research and marketing costs of the drug companies that stand behind the drugs, and this is often not understood.

They know that certain drugs can be obtained from some other pharmacy perhaps some distance away, or through some mail order listing, a great deal more cheaply than the local druggist will dispense it, and I think this causes a lot of the dissatisfaction, the fact that they are paying \$16.00 for something that can be obtained elsewhere for \$6.00, and they don't keep in mind the cost of what they are paying, the service aspect of the local druggist, and the privilege they have of going where they wish, and of the cost of marketing the product in the first place, and the quality control.

MR. RICE: Have you had any prescriptions or prices for prescriptions come to your attention that you thought were out of line, that is unduly high?

DR. FALLIS: Yes I think there are safety valves that exist. If the cost for a particular illness is catastrophic, if some person is on a very expensive hormone, or have polycystic kidneys



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They know that certain drugs can be obtained from some other pharmacy perhaps some distance away, or through some mail order listing, a great deal more cheaply than the local druggist will dispense it, and I think this causes a lot of the dissatisfaction, the fact that they are paying \$10.00 for something that can be obtained elsewhere for \$6.00, and they don't keep in mind the cost of what they are paying, the service aspect of the local druggist, and the privilege they have of going where they wish, and of the cost of marketing the product in the first place, and the quality control.

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and must be on doses for months at a time, in the first place welfare will help if the patient is indigent, and if the patient can qualify as a clinic patient at hospital, we might send them down, because drugs coming through the hospital are generally cheaper.

The local druggist himself, now I haven't had occasion to do this very often, but sometimes I have called him and discussed the case with him, and he will give up some of his profits, perhaps all of it in a particular case, as a gesture.

I would have the feeling also in a case of hardship that came to a doctor's attention, if he wrote to the drug company he might get a supply, or some help.

Also, sometimes there are maybe funds available even to the doctor from other sources. The patient may say: "Well now, if you are ever in difficulty regarding the cost of drugs, if you let me know I will be glad to help a case of genuine hardship", and this has happened in our office.

MR. RICE: I was not more or less referring the question to the case of hardship, although I thank you very much for that, doctor. But when you get complaints about the price of drugs and examine the druggist's invoice, would some of the complaints appear to be legitimate to you?

DR. FALLIS: No, in my own experience



and must be on losses for months at a time, in the first place welfare will help if the patient is intelligent, and if the patient can qualify as a clinic patient at hospital, we might send them down, because drugs coming through the hospital are certainly

limited.

The local pharmacist himself, now I

haven't had occasion to do this very often, but sometimes I have called him and discussed the case with him, and he will give up some of his profits, perhaps all of it in a particular case, as a gesture.

I would have the feeling also in a case of hardship that came to a doctor's attention, if he wrote to the drug company he would get a supply, or some help.

Also, sometimes there are private funds

available even to the doctor from other sources. The patient may say: "Well now, if you are ever in difficulty regarding the cost of drugs, if you let

me know I will be glad to have a case of genuine hardship," and this has happened in our office.

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in that district I cannot think of a case offhand that on checking with the druggist I haven't satisfied myself that it was clear.

They could give you more detail about how they work out the cost in a particular prescription, but it is clear that if they are dispensing say 24 tablets of a very inexpensive tablet, that their dispensing fee will be a larger percentage of the total cost of the prescription than if they were dispensing 200 of the same tablet, and this is a very frequent source of difficulty. To give an example, with a drug like the famous phenobarbital, if one prescribed a couple of dozen, the fee might be \$1.50, whereas for a hundred, four times as many, the fee might only be \$2.50, and if two patients got together and noted these were the same tablets and one had paid \$1.50 for 25, and the other had paid \$2.50 for a hundred, well I would very likely hear a complaint, and check into it, and this is the sort of explanation that usually turns up.

Again, it is the service aspect, and the recording, and handling, and bottling of it that the patient does not think of. He thinks of it in terms of a penny per tablet.

MR. SUTTON: In the case of hardship, do you ever check with the manufacturer to see if he would help?



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MR. SUTTON: In the case of a hospital,
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D/EMT/hm

DR. FALLIS: I never have, but I have had offers from a couple of manufacturers. I think in both cases they were large companies dealing in broad spectrum antibiotics. One was aureomycin and one, tetracycline.

MR. SUTTON: Did they not leave you samples of new drugs with the suggestion that you use them for welfare patients or indigent patients?

DR. FALLIS: Well, the conversation would come up certainly if they were handing samples over, but it is routine practise if they bring out a new modification of broad spectrum antibiotics, it is routine to leave four or eight or twelve capsules and the drawer is so full of samples that they don't wait there until an indigent patient comes in. They wait there until the first patient comes in who requires that drug, and it is usually given to them, and if they are a little hard up, so much the better.

MR. RICE: Can you tell us if there is a number of basic drugs that you would normally use when you prescribe? I think you said about ten before.

DR. FALLIS: I suppose I should have set this down, but I would think that aspirin and codeine, digitalis leaf and penicillin, tetracycline and some of the injectables such as morphine derivatives, and some of the atropine derivatives, and one or two tranquillizers, and



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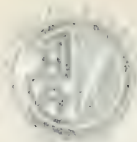


perhaps one of the newer anti-inflammatory drugs, such as Butazolidin. They are pretty well down the list. As I say, these are put up in tablets and capsules and liquid and ointments. It is certainly not a very long list that you use routinely.

I have one other thought I might make which is referring to your question about complaints regarding the cost of drugs. I think there is quite a variation in the patient's attitude from unexpected factors that the patient himself may not recognize. For example, the cost of penicillin for a child that has pneumonia is rarely begrudged, whereas if one is prescribing penicillin over a long period for an old senile patient, in whom the family have really lost interest, there is a lot of irritation. This may come out as purely regarding the cost of the drug.

I think the same regarding the condition a person might have. For example, an alcoholic requiring a tranquillizer. It is part of his defence mechanism to resent his illness and not admit responsibility for it, and this may express itself as resentment of the cost of tranquillizers.

There are many examples of those. I think perhaps an early unfortunate experience with the pharmaceutical or medical profession. There are patients who are very pleasant to look after, no matter what the quality of your service. They are extremely loyal and pleasant to attend to.



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Others that have had an unfortunate experience medically, they have had a lot of tragedy -- this sort of non-specific attitude towards the doctor and all his work may express itself I think in terms of the cost of the drug.

These are nebulous things, and they are hard to get at, but I see it every day, and I am sure they exist.

Of course, the difference in weight of a child as opposed to a 300-pound adult man is an important factor. The requirement of penicillin for a baby is very small; therefore the cost is not very great. And this is true -- the dose for a 70-pound woman is generally about half what is required for a 180-pound man. That cuts the drug bill in half. That is another factor of course.

MR. RICE: Do you have preference to certain manufacturers for some drugs over other manufacturers' drugs?

DR. FALLIS: Oh, I think only in the field of so-called quality control, I think that one is favourably impressed with the presentation of a long-term research programme that you know about that certain houses are active with, and the quality of their advertising, and the quality of their detail men, and the quality of their producing results, and you do get confidence in their work. This has been shown to exist as well. Their quality is high, and if one of the so-called very



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inexpensive drug houses produced the same product, I would admit being hesitant about using it, and in that sense I have a preference for quality products more than certain drug houses.

MR. RICE: I take it then under those circumstances you would prescribe by the brand name?

DR. FALLIS: Well, sometimes I would, yes. I think to give an example of that, the Burroughs Wellcome drug, a combination of aspirin -- aspirin and codeine, phenacetin, the common 222 or the Frosst combination, one knows those are good quality and they are very inexpensive anyway, and I would likely use the brand name for those products even though they are very common.

MR. RICE: Can you tell us how you keep abreast or keep up with the field of drug development? You see these detail men that the manufacturers send out? What, for instance, is the effect of their mailing and sampling?

DR. FALLIS: Well, certainly one sees the detail man, and many of them are quite well qualified obviously. They are pharmacy graduates and know the field quite well.

Here in the city, working in the out-patients department of a large hospital, one is bound to be discussing drugs and their advances all the time. Not only in the clinic, but informally around the hospital on the wards and so on, because testing is going on there all the time, and one



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hears the results.

Of course I think commonly one may hear about a product first in advertising in the medical journals, and it has become quite similar to other advertising. As you may know if you have looked in medical journals, there are new drugs presented there. One may hear about them first and read about them, but I think as far as going on and using them is concerned, usually we don't start off just on that basis.

One likes to hear that this has been used in a hospital, or talk to someone who has done a series with the drug, or one reads about it in the medical literature.

Most doctors take half a dozen learned magazines in which they hope to more than glance at a couple of them -- time is at a premium -- there is always information about drugs there.



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journals, and it has become quite similar to advertising. As you know if you have looked in medical journals, there are new drugs presented there. One may hear about them first and then read them, but I think as far as going on and writing them is concerned, usually the doctor writes off his on that basis.

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What doctors take half a dozen featured magazines in which they hope to more than glance at a couple of them -- time is at a premium -- there is always information about drugs there.



And then there is a bulletin which I take from the U.S. I can't remember the name of it offhand either, but it is a type of professional newsletter which comes out every two weeks and which is quite impartial, obviously with no commercial axe to grind; they take out a product and list what has been done and the claims that have been made and how it is coming along.

MR. WREN: Who publishes that?

DR. FALLIS: I may think of the name of it before the session is over.

MR. PRICE: Is that the medical letter we have heard about?

DR. FALLIS: Yes, I think it is.

MR. WREN: It is produced by medical people.

DR. FALLIS: Yes, by medical people. I think it is called the Newsletter.

MR. WREN: What does it cost to receive?

DR. FALLIS: I don't know. It is not cheap. It may be of the order of, say, \$10 or \$15 a year, and it comes out every couple of weeks.

MR. WREN: The Globe and Mail costs you more than that.

MR. RICE: Do you receive many samples, doctor?

DR. FALLIS: Yes, a great many. I would say that every detail man who comes leaves



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DR. FAIRBANKS: Yes, a great many. I

would say that every detail man who comes leaves



samples of at least one product. He usually has a major product which he wishes to talk about. These may be seasonal. For example, he may come in talk about antihistamines, for the usual summer complaints, and he might talk about this and that. He may leave samples of them all, or try to. Only half of the samples come in in this way. The other half come in in the mail.

MR. RICE: What do you do with these samples you receive?

DR. FALLIS: We try from time to time to keep them sorted according to their function. For example, we would try in the corner of the sample drawer to put all the antibiotics together, and if we wanted some particular preparation, let him have something from there. By no means every patient; maybe once or twice a day we would do this.

MR. SUTTON: Doctor, any samples of new drugs, the manufacturer would test them for at least a year before he would distribute anything by way of samples. When he gives you samples does the manufacturer expect that you will use it and give him a report as to what reactions you got? I mean, is there further experimentation?

DR. FALLIS: Honestly no, sir. I don't think so. I think that the detail man on his next visit will ask if you had an opportunity to use the product and what results you have had; but medically speaking, this would have no results.



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You would have to have a group on placebos and another group on another drug in order to give a report which medical eyes would pay much attention to.

MR. SUTTON: Do these samples really persuade you to buy that drug at future times?

DR. FALLIS: Well, I don't think their influence is very great. I don't think I could a yes or no answer to it. If it turns out to be a good product later on and it proves successful and you have started out in this way, it might impress you. But I think the medical audience is too sophisticated.

MR. TROTTER: I have made enquiries of my own and I have the impression that samples are just a waste of money insofar as persuading doctors to buy it. Would I be partly correct in that?

DR. FALLIS: I don't think I would put it quite that strongly. But if one were making suggestions as to how research and marketing expenses could be reduced, certainly this is something which may be discussed. I have no doubt they are taking a hard look at it. I think one's personal attitude and the type of practice he does would influence this. I could give a personal view. I don't want to be understood to be personal. I don't know whether I am speaking for the profession or not. I would be inclined to agree with you that too much of it comes in and my sample drawer finally fills to the place where nothing else can be put into it.



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So they are usually given away.

MR. TROTTER: In this matter of samples being used in, say, welfare cases or hardship cases, would it be correct to say that that amounts to very little help insofar as welfare cases need help?

DR. FALLIS: I don't know that I understand what you mean.

MR. TROTTER: I have heard it said on many occasions that the doctors use their samples to help those who are in need and who cannot afford to buy drugs. Do you think there is anything in that?

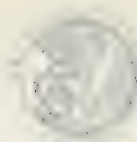
DR. FALLIS: I think that may be an important aspect in some areas of the Province. I think other doctors should be asked that.

MR. TROTTER: I gather from what you said earlier that it didn't make much difference in your practice.

DR. FALLIS: No, it doesn't to me, but I think in some areas, perhaps the downtown area, where people are having difficulties, perhaps the doctors may pay more attention to them, keep them in their drawers.

MR. TROTTER: I suppose these samples which you receive, once in a while, the vast majority end up in the garbage can.

DR. FALLIS: No. What we usually do with them is either put them in a larger box



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somewhere or we have on occasion called on the pharmacist and asked him if it would be of any assistance to have these and perhaps sort them out. I may be too Scots, but they are worth a good deal. My personal view is that in some ways it is paid for by my patients indirectly, and yet if one discusses this with a drug man he says in terms of their total budget this is really quite a small thing and is perhaps a legitimate marketing expense.

MR. RICE: Doctor, are you satisfied, personally, with the present arrangement with the manufacturers, with this promotional sales programme that they have?

DR. FALLIS: I think these marketing and distribution and advertising costs, from a personal point of view one would like to see them gone, and I have no doubt, as I have said before, that they are being gone over. But I think that the present system in which there is freedom of doctor, freedom of pharmacist, where the pharmacist is a responsible man, the drug company has freedom of research and there is competition between the companies and these other checks and balances such as hospital clinics, Sunnybrook and military hospitals - it is a complex picture, but it is a miniature of our economic system and I think it works reasonably well.

MR. RICE: I direct my question more to the question of the manufacturer, though,



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MR. BROWN: I direct my question more

to the question of the manufacturer, though,



educating the doctor as to his product. Would you advocate some other system than detail men coming to see you and this sampling and advertising, and on?

DR. FALLIS: As I say, I think that one hears about the product first that way. But I think the basic decision is made by your hospital contacts and your reading. I believe that the list that the dealer pharmacy puts out is widely read. If you are suggesting that companies might get together and sort of form a standard brochure, publication, which comes out and is being discussed in a good way fairly early in the history of these drugs, yes, but I think we have that to an extent now in the professional magazines and listings.

MR. RICE: There was a small manufacturer here and he said he spent 35% of his sales on this promotional programme. Is there some other way he could put his product on the market?

DR. FALLIS: I suppose this is true of many products on the market. It is a humanitarian medical product. I don't know if there is any better way of getting around it.

MR. RICE: Would you suggest a Canadian medical letter similar to this American publication you have referred to?

DR. FALLIS: I would certainly subscribe to it if there were one. I wonder if the circulation would be wide enough without it being



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advocate some other product than the one
see you and this would be an error.

Dr. FALLIS: As I say, I would like
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subsidized. The products there are all standard ones we are dealing with every day. There is not a great deal of difference on both sides of the border, as compared to the United Kingdom.

MR. RICE: If there was something like that coming to you, would you read it at your leisure?

DR. FALLIS: I suppose the main advantage of the detail man is that he does come in, you do discuss the product and he can answer questions, and he is competitive. I think competition is a good thing. Some of these aspects are absent in your reading. Your reading may be too leisurely and you may be too tired.

MR. TROTTER: There might be a different drug name but the drug may be in essence very much similar. Is there much difference in price there?

DR. FALLIS: You mean among the so-called mainline companies or suppliers?

MR. TROTTER: Say the mainline companies.

DR. FALLIS: I don't think there is a great deal of difference. I think some of the smaller companies might try to cut down on their marketing and their price may be less than some products and in the long run their sales will tend to go up. There may be the difference, say, between \$5 and \$8 on a common one.

MR. TROTTER: What would the quantity be in the difference between \$5 and \$8?



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to discuss the product and he has raised questions
and he is competitive. I think competition is a
good thing. Some of these reports are absent in
your reading. Your reading may be too leisurely and
you may be too tired.

MR. TROTTER: There might be a differ-
rent drug name but the drug may be in essence very
much similar. Is there such difference in price

DR. PEARCE: You mean among the so-
called medicine companies or suppliers

MR. TROTTER: Say the medicine companies.

DR. PEARCE: I don't think there is a
great deal of difference. I think some of the
smaller companies might try to cut down on their
marketing and their price may be less than some pro-
ducts and in the long run their sales will tend to
go up. There may be the difference, say, between
\$5 and \$8 on a common one.

MR. TROTTER: What would the quantity
be in the difference between \$5 and \$8?



DR. FALLIS: I was thinking of a standard preparation, for example, 50 meprobamate and tranquiline. I think at one time there was the sort of difference in a standard supply to a patient.

MR. TROTTER: Do the prices tend to come down once it has been on the market?

DR. FALLIS: Yes, with the competition.

MR. SUTTON: What about labs which don't use detail man or advertise in any form?

DR. FALLIS: They do advertise in the medical journals, and I think any major breakthrough would come in various ways. But you read about it all right.



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F/MR/hm

MR. RICE: Are there any recommendations you can make to this Committee as to how the price of drugs could be lowered?

DR. FALLIS: I think the -- I am not familiar, in my ignorance, with the terms of reference of the Committee, precisely what the plan is but I would think that as in any field just the fact that a Committee is in being and that witnesses are being examined is an extremely healthy thing.

I would expect that you would, if nothing specific is actually done that many of the manufacturers will take a very close look at their operation. This would be my guess. I think it is important that you keep in mind quality control not just price on tender. There must be some control over the product and to have competition without duplication, to have research without wasted products on your pharmacist's shelves, I think you are in very heavy weather indeed. I think it is difficult.

Your suggestion of a Canadian Letter has probably been considered before. While it exists in some form already it might be presented on a more official basis. A great deal of this has been done already, of course.

MR. RICE: Mr. Chairman, any other members of the Committee have any questions?

MR. TROTTER: I have a few questions. Dr. Fallis, in regards to quality, have you in your experience very often come upon drugs of poor



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MR. TROTTER: I have a few questions.

Dr. Fairbanks, in regard to quality, have you in

Your experience very often come upon drugs of poor



quality?

DR. FALLIS: No sir, I haven't but through hearsay I have heard that it has occurred. You may come upon it here, but even in a hospital set up where drugs are being bought this sometimes can happen. I also recall in the newsletter that I told you about, a survey that was done there on one common barbituate, I have forgotten whether it was the so-called Pentobarbital and there was quite a variation, not so much in the quality as the amount of the chemical that was put into a capsule. Quite a variation in the thing.

If you want to give a patient a grain and a half of secobarbital at bedtime and you are not sure whether you are getting three-quarters of a grain or three grains in a capsule that is a serious loss of quality control even though the chemical itself is not adulterated.

I do know also that it is hard, even for the experts to check on some aspects of quality and it boils down, apparently, to integrity in manufacture. It can't be checked on.

MR. TROTTER: Have you had much experience or knowledge with the Italian drugs that have been coming into the country of recent date?

DR. FALLIS: You mean going over or coming in or have I used them?

MR. TROTTER: Have you any knowledge if they are any good or if they are bad?



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DR. FALLIS: Not directly, no. The price lists come in across the desk. One looks at these.

MR. TROTTER: Has it come to your attention any unfortunate experience of other doctors unfortunate experience they have had because of these Italian drugs?

DR. FALLIS: No, just this case I told you about of a hospital situation in which drugs were bought on tender and should not really go into evidence because I can't recall the details of it exactly.

MR. TROTTER: From your knowledge and from your general practise would I be correct to say that there are really very few instances of poor drugs on the market? I am not saying there aren't any. I am saying there are very few.

DR. FALLIS: Yes, in my experience that is true with the qualification that I made about the amount of drugs being dispensed in a given tablet or capsule which I think is important.

MR. TROTTER: Could it be possible that a lot of this quality control, talk of quality control is overdone? You see the high cost of drugs is in many cases blamed upon quality control and I was wondering could it possibly be overdone?

DR. FALLIS: Yes. I am sure in some drugs perhaps it could be but I think again that the eyes of the Committee plus competition would tend to put a finish to that. I can't help thinking also



about some biological products that go stale, or some combinations of vitamin products which may go stale. I would think that the -- take a standard pediatric vitamin, I would think that the quality control there would be hard to assess, hard to put on paper, hard to evaluate.

MR. TROTTER: Now there are many new drugs coming out on the market but are not a lot of these drugs just a small variation of one essentially new drug?

DR. FALLIS: Yes, I believe that is true.

MR. TROTTER: Would it be correct then to say that a lot of research involved in one new drug, the essential drug then in all these variations there would be really little research to them?

DR. FALLIS: Yes, I think that is sometimes true. I think it would be hard for them to tell in advance, however, what their research was going to produce. That's the trouble. They do a tremendous amount of work and they have paid their money and it isn't so different from some other product.

MR. TROTTER: When you prescribe a drug for a patient and you know just how much money there is, is there any tendency to give a prescription for a smaller number of tablets and have the patient come back a number of times? Or renew the prescription a number of times?



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DR. FALLIS: I am very cost conscious of prescriptions and I certainly, no matter who it is certainly would be careful of that. I think that if a patient is obviously short of funds that one would be doubly careful but I think that most doctors would not underprescribe for what they thought was essential, then if a patient said "Doctor how much is this going to cost me?" you will say it's going to cost \$10.00 or phone the druggist and find out what it is going to cost and if he said I simply can't pay for it, then I think you would refer him to one of these other channels I mentioned. I don't think it comes up terribly often. I mean like sending them down to a clinic or getting the druggist this time to give them some help.

MR. TROTTER: When you prescribe the drug by generic name is there much saving between the generic name and the brand name?

DR. FALLIS: I think that varies a great deal from product to product and it would depend generally on the service aspect of the pharmacist who fills it if he felt that -- I am sure he would have available products that may be a lot cheaper and he might in his judgment feel that he did not have enough confidence in the quality of the product use something perhaps just a little less expensive than the most expensive.

MR. TROTTER: One last question --



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DR. FALLIS: Excuse me sir I think as one goes along that drugs, for example, penicillin that this tends to get a little to the place where there is a good standard quality after a while and the drug tends to cost about the same from various suppliers. Penicillin is a good example and perhaps the A.P.C. of C. ones that I mentioned are the same.

MR. TROTTER: We have heard a lot about the average cost of drugs. Would you not find that from your experience it is not the average cost of drugs that is important but it's to the particular small group of people that it hits hard. I think you used the words it would really sting, that is, the cost of drugs. For example, would not the main cost of drugs be borne by people who are old? Who suffer from arthritis? Is that not so, or for people who have a chronic disease like arthritis?

DR. FALLIS: I would want to take a look at that. I think older people certainly buy their share of drugs. Their incomes are less if they are retired. I don't think there are a great many complaints from them. Possibly much easier, on the whole, to refer them to the clinic if that were necessary. If it were a real hardship, it's easier to get help for them.

THE CHAIRMAN: Any questions?

MR. WREN: Mr. Chairman, I just have one question. I have had some instances where people who are not indigent but are in some



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straitened circumstances and their drug bill runs in the nature of \$650.00 a year for drugs they must have in order to continue with their employment. In one case, a chronic condition of asthma which requires repeated drug treatment. Now most manufacturers, most wholesalers have pharmacists on their staff. Is there any reason, is it unethical or improper for a physician to prescribe the amount of drug this person would need in continuity and have it filled at a wholesale cost or a reduced cost by one of those wholesalers or manufacturing firms?

DR. FALLIS: No sir. I don't think so. I think it would be proper for a chronic condition to write a prescription for a drug supply for a year but it isn't directed where that is taken and I think those are remarkable cases; relatively unusual and I feel strongly that something has to be done.

MR. WREN: I have in mind two specific cases that came to my attention recently and their bills are continuing to run in excess of \$600.00 a year.

DR. FALLIS: Something should be done all right.

MR. WREN: When I attempted to do something I was -- I don't want to bring names into this -- I was told it was unethical or perhaps improper that a wholesale house or a manufacturer could supply this even though the prescription was



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actually compounded by a licensed pharmacist. As far as you know --

DR. FALLIS: I was thinking as far as writing the prescription is concerned. One often writes sufficient digitalis for six months in a clinic and thinks nothing of it and I don't see anything wrong with the doctor doing that provided he satisfies himself that the condition will continue and this is quite often done in order to avoid rewriting them and the patient goes to the local druggist and gets a hundred tablets at a time; only comes back every year or so.



dpw

MR. WREN: Well then, as far as you know would there be anything improper from the pharmacist's point of view who is on that staff in filling them?

DR. FALLIS: Well, I think a pharmacist should be asked that, because I am not familiar with their code.

MR. WREN: I don't want to put you in a spot --

DR. FALLIS: I really don't know what their ethics are about that, but certainly from a doctor's point of view, I think that a \$600.00 drug bill a year is in the catastrophic range, and certainly some arrangement should be made if we want to keep on with the other advantages of the present system, to look after this.

MR. WREN: If it were your patient, you would have no hesitation in seeking some arrangement to assist the patient?

DR. FALLIS: Oh, no, I would feel confident that some arrangement could be made.

MR. PRICE: How does one qualify as a clinic patient? You mentioned earlier about clinic patients.

DR. FALLIS: Well, I can only speak informally about the Toronto General, but it is an, as far as I understand it, an economic scale, worked out by skilled persons, social workers I mean, on the basis of the marital status, the family



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responsibilities, the number of children, the amount of savings, and whether they are unemployed and so on. This applies however only to most of the clinics in the hospital, and one should not get the idea that this just means welfare patients.

There are many patients who are unemployed, or on unemployment insurance, or it has recently run out. They will come out and there will be a little more on their face sheet. They have qualified for clinic, but it says one-quarter, or one-half, or one, and that means the fraction of the nominal clinic fee they must pay.

It mostly includes the chest, the hay fever clinic, and possibly some technical clinics. I am not sure of this. Vascular surgery perhaps. Clinics that are probably supported from provincial sources or otherwise.

MR. PRICE: To what extent are drugs tested prior to being available to the general public?

DR. FALLIS: I don't think I could help you with that.

MR. PRICE: Do you approve of a pharmacy committee directing that a substitute be made for that prescribed by the doctor?

DR. FALLIS: In the hospital, or what?

MR. PRICE: In the hospital?

DR. FALLIS: You mean after the fact, or before the fact? Do you mean if a prescription



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is written, it goes down, and they don't have it in stock, and there is a regulation there from a committee saying that every prescription for such-and-such, that such-and-such is to be given.

Well, I think it might be a necessary evil from the point of view of hospital costs, and I would feel that it would depend a great deal on the nature of the committee. I think in one's own hospital, one would be content with this, because it would be very reasonably done, I am sure.

MR. PRICE: At the retail level this would not be considered ethical from the standpoint of the pharmacist. He is to fill the prescription as directed. We find in hospitals they sometimes have a pharmacy committee with its own policy, and they substitute a similar product to the one prescribed by the doctor.

DR. FALLIS: I think that the ethics of this are accepted by the doctor operating in that hospital and continuing his affiliation there, knowing the pharmacy committee has been set up, and possibly he will be called upon to serve on it, and can say let us bring this before the committee, and he would accept it.

There might be a point where this would apply to private patients, you are probably thinking of the word patient mostly?

MR. PRICE: Not particularly. In your experience, does the financial status of the



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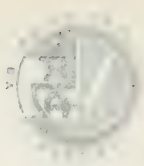


patient have any bearing on his attitude towards the cost of drugs?

DR. FALLIS: I think sometimes it has, most particularly, generally I think some are in genuine difficulty financially. I think others may have hidden irritations, perhaps because they are unemployed, and things are going desperately across the board. That same person might have trouble the same day with a couple of other things that might come along.

MR. PRICE: Do any of your well-to-do patients complain about the high cost of drugs?

DR. FALLIS: Yes, I think I used the word sort of good-natured irritation. This is heard occasionally all right. I think that in most of those cases it is due to lack of understanding, and again hidden feelings. To be specific, if someone is very respectful to me, and tells me what a wonderful diagnosis I have made, but they don't really feel that. What a wonderful way to exhibit that, by teeing off on the cost of medication. It satisfies them and isn't discourteous to me, and unfortunately the difficulties fall in the wrong place. I think that happens quite often. It is the same as taking a medication. They are very respectful, and very helpful, and then a tremendous number of side effects from the drug; "Oh, doctor, those pills give me headache and nausea", and all that. This is perhaps a disinclination to



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place oneself under care.

MR. PRICE: Irrespective of the financial status of the patient when they complain about the cost of drugs simply because of other causes, that may just be a complaint irrespective of what the cause may be?

DR. FALLIS: Yes, I feel that very strongly. Perhaps it is quite a significant percentage in our complaints about drug cost.

MR. PRICE: They are only exhibiting irritation about something else, but it just comes out in this way?

DR. FALLIS: I think that is very common.

MR. WREN: Do many seek, or would rather have a costly drug?

DR. FALLIS: Oh, yes.

MR. WREN: They feel they are not getting good treatment unless it is costly?

DR. FALLIS: Yes, the same is true of other costs. People wish to go far abroad for expert opinion and other things of this sort. It is only natural.

THE CHAIRMAN: I was interested in your reference to the out-patient clinics, and I was wondering about your opinion of the rural Ontario, I mean in a big city like Toronto these services might be available, but in the smaller centres and rural areas they would probably be just



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not there, and I was wondering if you had any suggestions of whether or not there should be a descriptive list made up by the medical profession as to what were chronic cases that require extensive and continued medication, that some system might be worked out on specific terms, on which people might be able to qualify for drugs at a lower price, provided they met those qualifications and were authorized to receive those treatments at a lower price by a competent person, such as a physician or medical board. Do you think something like that would be --?

DR. FALLIS: No sir, I think you should ask one of the physicians from a smaller centre about that. I don't think I could help you with that.

I think in general I would feel that for every regulation we give up a little liberty, and sometimes this has to be done, but for a local situation I think you should ask one of the men there.

MR. RICE: Thank you very much Dr. Fallis.

DR. FALLIS: You are welcome.

MR. RICE: We also have this afternoon Dr. Maurice Clarkson of the Peterborough Clinic.

For the purposes of the record, would you state your full name?

DR. CLARKSON: Maurice Frazer Clarkson.



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MR. RICE: I understand you are a
licensed medical practitioner?

DR. CLARKSON: I am.

MR. RICE: Where do you carry on your
profession?

DR. CLARKSON: In Peterborough,
Ontario.

MR. RICE: Are you attached to any
clinic, or?

DR. CLARKSON: Yes, I am a member of
a group known as the Peterborough Clinic.

MR. RICE: What does that group com-
prise?

DR. CLARKSON: It comprises one
general practitioner, four internists, three sur-
geons, one obstetrician and gynecologist, one ear,
nose and throat man, one ophthalmagist, one anes-
thetist. I think that covers it all. Fourteen
doctors in all.

MR. RICE: Which classification do
you come in?

DR. CLARKSON: I am an internist.

MR. RICE: When did you graduate?

DR. CLARKSON: 1942.

MR. RICE: From what university?

DR. CLARKSON: Toronto.

MR. RICE: After graduation, did you
do any post-graduate work?

DR. CLARKSON: I took a year junior



MR. RICE: I am not interested.

MR. CLARKSON: I am not interested.

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rotating internship, and then was overseas four years, and then four more years post-graduate internship.

MR. RICE: Do you have a prepared statement that you wish to deliver to the Committee?

DR. CLARKSON: No I haven't.

MR. RICE: In addition to the clinic, are you on the staff of any hospital?

DR. CLARKSON: Yes, two hospitals, Peterborough Civic Hospital, and St. Joseph's Hospital, Peterborough.

MR. RICE: In the course of your profession, do you prescribe drugs for patients?

DR. CLARKSON: Yes sir.

MR. RICE: Would you give us approximately how many prescriptions per year you would write?

DR. CLARKSON: Well, we are in a little more difficult position than a doctor in private practice, in that we have a dispensary associated with our group. To answer your question specifically, I got the dispenser to look up the number of prescriptions that I would prescribe in one month only. Not an average, a chosen month, and it was 101. I have a comparison with another internist, who does about a third more practice than I do, and he prescribed 200 prescriptions.

MR. RICE: You mentioned you have a dispensary in connection with your clinic?

DR. CLARKSON: That is right.



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MR. RICE: You mentioned you have a

dispensary in connection with your clinic?

DR. CLARKSON: That is right.



MR. RICE: Would you tell us something about that dispensary. How many different drugs do you carry in your dispensary?

DR. CLARKSON: I can only tell you the cost of them. The overhead is approximately \$12,000.00.

MR. RICE: That would be the value of the drugs inventory?

DR. CLARKSON: Yes sir.

MR. RICE: What would be your annual turnover in that department?

DR. CLARKSON: I would be perfectly willing to give these figures for this Committee. I feel that because of our community and what-not, I don't feel this should be made public and quoted as to the business transactions that go on in our partnership.



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H/EMT/hm

I have a lot of figures here that I think would be helpful to you, but I think they are our private business, and I am wondering if there is any way in which we cannot have them appear in the press or be available to the public if they are asked for.

MR. RICE: I think, Mr. Chairman, under the circumstances we will file them with the secretary and perhaps they would be available to the Committee. I am not sure, since these are public hearings that we can go right along the line perhaps ask the press to extend the courtesy to the doctor in this matter.

MR. WREN: I should say also that there is a transcript made of these proceedings.

DR. CLARKSON: This I realize.

MR. WREN: And these transcripts have a very wide circulation, and if the figures are in that transcript --

DR. CLARKSON: I realize. This is why I brought the question up.

MR. RICE: Perhaps if they are filed with the secretary they need not appear in the transcript.

MR. WREN: I would suggest, Mr. Chairman, that any matter which is of vital importance as far as presenting figures is concerned --



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DR. CLARKSON: It is our business.

MR. WREN: I would suggest that answer could be filed with the secretary.

THE CHAIRMAN: I think that would be a very good way of taking care of it, Dr. Clarkson. Of course we have no desire to embarrass you in any way.

DR. CLARKSON: But I think it would be interesting to the Committee to know these facts, and I think it may be helpful too.

MR. RICE: Can you tell us generally, without naming any figures, what you will file with the secretary so that the members will have some idea of what the information is so they won't ask any questions?

DR. CLARKSON: Perhaps if I said that we issued 28,000 prescriptions in a year, in 1960. The average cost of our prescription is about -- I'm sorry, this is 1960 -- \$2.61.

MR. RICE: Can you tell us from where you purchase the drugs for your dispensary? Not specifically the drug house.

DR. CLARKSON: We have two registered pharmacists running our pharmacy, and they do our purchasing. One of them does our purchasing from wholesale houses.

MR. RICE: And can you tell us at what discounts you are able to purchase your drugs?

DR. CLARKSON: As a rule we get ours



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what discounts you are able to purchase your drugs?

DR. CLARKSON: As a rule we get ours



from 40% off list. I think it varies from 40 to 33-1/3, or something in that neighbourhood.

MR. RICE: When your dispensary dispenses a prescription, how do you charge the patient for this? Is there a separate prescription charge?

DR. CLARKSON: It varies with the cost of the drug. In dealing with a drug like achromycin or tetracycline, which is a high-cost drug, 16 capsules, which is a usual quantity to dispense, is listed at \$7.90, and we get 40% off; \$4.74 for 16. Now, it is dispensed at that same price, the list price, without dispensing fee.

MR. RICE: That is at the \$7.90?

DR. CLARKSON: That is right. We do this because we feel that the mark-up includes any cost of handling the prescription that we might have.

Now, if you go to the same drug, and instead of 16 being prescribed, there is a different way of working it out apparently. If we order 12 capsules, they would be charged at 50¢ apiece plus 75¢ prescription fee, which would give a total of \$6.75 for 12 and \$7.90 for 16.

MR. RICE: This is the pricing policy at your clinic?

DR. CLARKSON: Yes.

MR. PRICE: Do you prescribe in your clinic, or supply I mean through your dispensary, drugs that are prescribed only by doctors in the clinic, or do you dispense drugs that are prescribed



by other doctors as well?

DR. CLARKSON: There are three doctors whose offices are right within the area of our building, and a very small percentage -- I asked the dispenser this -- maybe one or two a week might come in to have a prescription filled, but they too are generally patients who might go to one of the doctors in our group and who have been accustomed to coming to our dispensary for their medication.

MR. RICE: Is there any policy in your clinic in this regard as to whether you are only going to sell to patients of doctors in the clinic, or whether you will dispense to any person who has a prescription?

DR. CLARKSON: I think basically our principle is this: We are not in competition with the drug stores, with the pharmacies and drug stores. We are inclined to supply a service for our own patients.

MR. WREN: In addition to your usual professional services, do you feel you are saving your patients money as well?

DR. CLARKSON: Well, sir, the average apparently is, and I quote from the periodical put out by the Ontario College of Pharmacy, the average prescription rate in Ontario in 1959 was \$3.21. Our average was \$2.41.

We feel we are saving them some money, and we feel also we are affording them some services



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which are not available in some of the pharmacies, drug stores. For instance, and I think this is an important point, I might prescribe achromycin or tetracycline for a patient, and that would cost him \$7.90. He may be sensitive to it. It may cause vomiting after he has used two capsules.

We would then take the remaining capsules back and exchange them for a different antibiotic, and credit him with the amount. Now these are things where we can help out our own patients. We can afford them a service that I think a person serving the public as a whole is unable to do.

MR. WREN: Do you feel -- let me get the philosophy of your policy -- do you feel that the same result might be obtained if the registered pharmacists who provide drugs in your area were to devote their full professional time to pharmacy?

DR. CLARKSON: I have got no idea on this, sir. I am not a druggist, nor manager. I don't know. We are unique in that we don't sell anything but drugs. We sell no toiletries, et cetera, and it is only medication that we sell through our pharmacy.

MR. WREN: I am guessing out loud, 28,000 prescriptions -- you don't have to agree with this amount -- with 28,000 prescriptions, you might be in the \$65,000.00 class in Ontario, for the pharmacy.



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MR. WHITT: I am guessing out loud,
28,000 prescriptions -- you don't have to agree with
this amount -- with 28,000 prescriptions, you might
be in the \$25,000.00 class in Ontario, for the



DR. CLARKSON: Might be.

MR. WREN: I am just guessing. If two druggists in independent practise were doing that kind of turnover in the vicinity, they would perhaps devote their full time to pharmacy?

DR. CLARKSON: I wouldn't know the answer to that really, sir.

MR. RICE: Can you tell us if your pharmacy operates in the red.

MR. CLARKSON: No. We make a profit on our pharmacy.

MR. RICE: You take into consideration in the operation of your pharmacy the wages that you pay to the registered pharmacists, and a certain percentage of the overhead and so on?

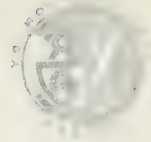
DR. CLARKSON: Yes.

MR. RICE: Are mostly the prescriptions in trade or generic names?

DR. CLARKSON: Mostly in trade.

MR. BOYER: Would the witness like to say why or expand on that a little bit?

DR. CLARKSON: We leave the purchasing up to our pharmacist. He is a man we trust. He is a professional man, and we feel that he knows the quality of medication that we desire in our group. We frankly cannot -- have not the time to sort into every single drug available and find out, if we knew where to find out, whether it was a quality drug or not.



DR. CLARKE: Yes, sir.

MR. WATSON: I am just asking you two

doctors in independent practice who do not

kind of turnover in the industry, they would not

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DR. CLARKE: I wouldn't know the

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MR. WATSON: No. We make a profit

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you pay to the registered pharmacists, and a certain

percentage of the overhead and so on.

DR. CLARKE: Yes.

MR. WATSON: Is mostly the prescription

in issue or general interest.

DR. CLARKE: Mostly in issue.

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When you are dealing with the amount of medication that we are putting out, if we didn't have our pharmacists, one of us would have to supervise, and this would be impossible supervising the prescribing of drugs.

The second thing is that I am sure if there was a central point from which we could get reliable information with respect to biological activity, purity, constancy of dose, that we would be perfectly willing to prescribe by generic name, but we must have the assurance that what we are prescribing is a reasonable or has a reasonable constancy to it.

MR. RICE: Is it a practise in your clinic, is this more or less a regulation of your clinic to buy by trade name rather than generic name?

DR. CLARKSON: No regulation whatsoever.

MR. RICE: Just what the doctors --

DR. CLARKSON: We all have our own pet drugs which we are accustomed to, which we know. We know which way they will react. We know what side effects to expect from them, and we all tend to stay on our own experience in using drugs.

Mind you, there is also some limitation in the numbers of tetracyclines that we have on our shelves. We do this by agreement amongst ourselves. We will say "Let's not stock all six types. What is the use of them?", but maybe a pediatrician will come up and say they want to use a certain brand because they have a reason for it,



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and we will stock that for them as well as long as they have a reason.

It is really left to the judgment of the pharmacist pretty well. If he has any problems he brings them to the practitioner for discussion.

MR. RICE: The hospital to which you are attached, do they have an out-patients department?

DR. CLARKSON: None.

MR. RICE: Do they have dispensaries?

DR. CLARKSON: Yes.

MR. RICE: Can patients at these hospitals purchase drugs from the dispensary at the hospital?

DR. CLARKSON: No.

MR. RICE: Do you have a number of detail men --

DR. CLARKSON: Yes.

MR. RICE: People calling on you?

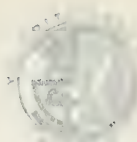
DR. CLARKSON: Yes, a lot of them.

MR. RICE: And what is the attitude of your clinic, if I may ask if it has an attitude?

DR. CLARKSON: The attitude of my clinic -- there is no attitude of the group. There is no official attitude towards detail men with respect to the group. May I speak personally now?

MR. RICE: Yes. I was not right on detail men particularly. I was aiming more or less at the general system the manufacturer has to resort to.

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at the general system the manufacturer has to resort

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DR. CLARKSON: Well, they all come in



and sit outside my office and at six o'clock when I think I am finished, I go out, and there are two or three sitting there waiting, and they do this individually with each one of us in the group.

My attitude towards them, I have told them I am interested not in a description of a lot of drugs they are trying to sell; I am interested in anything new that they bring out and anything that has a specific chemical for a specific purpose. This is my attitude towards them. The detail men are trying to sell medications, one in competition with another, and they want to come in and they want to tell you why their product is better than the other fellow's product, and it may be exactly the same type of a medication. This to me is a waste of time, fundamentally. Personally, I am talking now. Personally, it is a waste of time because they don't sell me on it. I know they are trying to sell their product. I just can't think up enough questions to find out what is wrong with theirs as well as what is wrong with the others.

Take A.P.C. of C., as an example. Frosst sell them as 222's, and somebody else sells them on some other name. To me they are all the same, and I think they are all of the same quality. I order A.P.C. of C. -- I suppose I order by generic name this way.

MR. RICE: Is there any other method that you recommend or you would advocate whereby the



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MR. RIGBY: Is there any other method that you recommend or you would advocate whereby the



manufacturers could make their information available?

DR. CLARKSON: I smiled when you asked Dr. Fallis this question, and you asked about the medical literature. My nurses have directions to file all medical advertising in the wastepaper basket. I can't go through it. I have a pile this high every day, and I can't get through it.



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/dpw

Really fundamentally to me personally I don't read it. If I want to learn about medications and drugs I learn from people who have been using them, I learn from the hospitals, from the people with whom I correspond and with whom I would discuss cases at the general hospital here or some hospitals.

MR. TROTTER: What happens to your samples?

DR. CLARKSON: I keep all my samples. We can't afford medications, and they are awfully useful, terribly useful.

MR. TROTTER: Do all the doctors in the clinic do the same?

DR. CLARKSON: I have no idea.

MR. RICE: Do you have any complaints from patients about the price they have to pay for prescriptions?

DR. CLARKSON: They decrease with the time the doctor tries to take to tell them why they are on drugs. If the doctor will sit down and say: "Now, look, you have pneumonia. Ten years ago if you had this pneumonia I would have had to make a house-call on you once a day and give you a shot of penicillin, and I might have to do this ten days. This would be \$5 a house visit plus medication, which may be another \$5 or \$10. Now, I give you ten capsules of tetracycline which costs \$6.90". I think the patients don't complain about the cost.



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MR. RICE: You feel that the person who complains about the prescription, is it due largely to lack of understanding about what goes into the cost?

DR. CLARKSON: Yes, because drugs are tremendously useful in keeping the cost down in the long run. You raised the question of the patient, chronic patient on long-term medication. We make sure that the patient will get his medication regardless of the cost. The interests of the doctor can procure medication for a patient if it is absolutely necessary. There are many ways of doing it. You can do it through the Welfare Department, if the patient is on welfare; secondly, there are societies which provide medication for people who need it over a long period of time. Now, this takes time, but it is one of our responsibilities.

MR. WREN: In one instance, the case of a man who is on seasonal employment, a carpenter to be specific. He works perhaps eight or nine months of the year, but he must have constant medication and he runs into a staggering bill of \$50 a month. Is there anything unethical or improper in arranging for a supply of drugs to keep that man supplied?

DR. CLARKSON: I would ask the pharmacy, the medical house to supply it. I would turn every stone upside down to get it for him. This is a basic philosophy. We won't charge him,



MR. RICHARD: You said that the person who

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DR. HARRISON: That is because it is the

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but we will tell him he will get the medication, and if he can pay something, all or part, we will be glad to see it.

MR. WREN: If there are no facilities such as yours, would there be anything improper in arranging with a wholesale house to supply on your prescriptions?

DR. CLARKSON: No, I don't think so. And I would go to the manufacturer rather than a wholesale house. This is what I would ask the detail man who came to my office.

MR. RICE: Have you ever had any comments from your patients in comparing the price they would pay in your dispensary and the price they pay from the retail pharmacist?

DR. CLARKSON: Yes, and it comes out when small amounts are required. Say a mother has a three or four year-old child and she takes him to the pediatrician and he gives her a prescription for six tablets and then the mother may come to me and she may be under stress and I may supply her with a hundred sodium amytal tablets. The cost is tremendous; the smaller amount of the prescription is the more costly each pill is or each dose is in that prescription. It may be the same price, it may be exactly the same cost per hundred. But again if you were to - for instance, I have here a note. In the dispensary, products listed at \$10 or less, and the schedule is according to the

but we will tell him we will not. The manufacturer, now
if he can pay something, all on hand we will be
glad to see it.

MR. WATSON: It seems to me no limitation
such as yours, which there is a strong tendency to
arranging with a wholesale house to supply on your
particular terms.

MR. LARSON: Yes, I think there is.
And I would go to the manufacturer and say
wholesale house. This is what I want, and the
detail man who came to me offered.

MR. KILB: There you are, and why
comments from your patients in connection with this
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they pay from the retail pharmacist.

MR. LARSON: Yes, and it costs the
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Ontario College of Pharmacy in present use. A hundred tablets of a certain diurectic would cost \$7.75, twelve would cost \$1.85, twenty-four would cost \$2.85. The cost is greater the smaller quantity prescribed.

MR. RICE: Do you find this another factor that the public are unaware of when they are trying to compare the cost?

DR. CLARKSON: Again it is the personal contact with the patient. If you explain it to them they understand it, and really we have very few complaints.

MR. RICE: Would you say that the public are unhappy about the costs of their prescriptions from the retail pharmacist? If the retail pharmacist would explain his account to them --

DR. CLARKSON: I think the patient should get smart and ask the doctor for a large number the next time.

MR. RICE: Do you ever receive any complaints from the retail pharmacists in Peterborough about the price of prescriptions?

DR. CLARKSON: We are all very happy in Peterborough. There are two groups in Peterborough; the other group also has a dispensary, and there are 22 other drug outlets in the city, and we rely on the drugstores for all medications after about 6 o'clock in the evening and they get a fair amount of work from us. Now, on the whole we do not have any complaints about people buying



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we do not have any complaints about people paying



them from the drugstore or the dispensary. They don't come in complaining about differential in price. There have been some flurries where people have been trying to get rid of an overstock, but as a rule it all levels out.

MR. WREN: What happens when a patient in your clinic compares his bill from one from the drugstore?

DR. CLARKSON: Well, when they come in we explain it, and once you explain it they accept it. But the trouble comes when you don't take trouble to sit down and tell them.

MR. WREN: Someone may get a prescription from your clinic and another person got it at a different price from the pharmacist. Is there anything said about that?

DR. CLARKSON: Not particularly. The man is in business, he has overheads and he has to cover it.

MR. RICE: You have a sort of formulary?

DR. CLARKSON: No, not a formulary written, but the pharmacist says: "You are going to be using this drug. How many brands do you want?" and we may settle on one or two brands.

MR. RICE: Do you agree with Dr. Fallis that there are probably ten to twelve basic drugs that you more or less prescribe constantly?

DR. CLARKSON: I will go back to my quote. I issued prescriptions of 26 varieties and



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MR. WILSON: Do you agree with Dr.
Wallis that there are probably ten to twelve basic
drugs that you more or less prescribe constantly?
DR. CLARKSON: I will go back to my
quote. I issued prescriptions of 25 varieties and



my partner issued 41 varieties in one month. We just took it as a month. We assume it is.

MR. RICE: Are there any recommendations that you could make to the Committee as to how this Committee could lower the prices of drugs?

DR. CLARKSON: I know nothing about manufacture of drugs. I could not enter that field. I don't know myself whether the cost of drugs is excessive or not. Fundamentally, I feel if we had time to discuss with our patients, and we are selling it at a reasonable price. I don't think that our patients object to buying our drugs at our price. As a matter of fact, we had an interesting experience some time ago where we changed our sales in pharmacy over from billings to cash sales. We notified our patients about it, and there were only two patients out of our whole clientele went to the drugstore to buy them. We thought that was a very good recommendation.

MR. RICE: I take it you don't try to direct where the patient may buy their drugs?

DR. CLARKSON: No, not at all. As soon as you hand a prescription to a patient it is his property, he can do what he wishes with it.

MR. RICE: Mr. Chairman, do you have any questions to ask Dr. Clarkson?

MR. PRICE: Is there any relation between the financial status of your patients and their attitude towards the cost of drugs?



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MR. PRICE: Mr. Chairman, do you have any questions to ask Dr. Clarkson?

MR. PRICE: Is there any relation between the financial status of your patients and their attitude towards the cost of drugs?



DR. CLARKSON: I think there has to be. I mean, you don't ask a person to go out and buy a T-bone steak who can only afford a hamburger, and I feel if you know the patients, that they are ill, you know what their response is going to be towards the cost of drugs. This is where I feel that the function of the doctor is most important, that he gets the treatment he needs, not a cheaper product, and if we have to do it we have to do it. We want these people to come to us for the rest of their lives.

MR. PRICE: Would you object to your pharmacist substituting a similar product to the one you prescribe?

DR. CLARKSON: He would only 'phone us and ask us. In our case he only has to pick up the intercom and speak to us.

MR. PRICE: They are filled as directed?

DR. CLARKSON: Yes, unless he checks with us.

MR. PRICE: Unless he didn't have a particular product in stock it would be filled as directed?

DR. CLARKSON: Yes.

MR. PRICE: Do you consider the cost of drugs excessively high?

DR. CLARKSON: I think I answered that a few minutes ago, where I felt that with the better drugs we have now we have actually diminished



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the cost of medical care.

MR. PRICE: In your experience what percentage of your patients are under a hardship because of the cost of drugs?

DR. CLARKSON: I don't know how to answer that question. I think there are a percentage that are. If we know about it we do what we can to help.

MR. PRICE: Along the lines you have explained?

DR. CLARKSON: Yes. We have examples of that that come through all the time. There is one epileptic boy who is on three different anti-epileptic drugs. We arranged to get him his medications by arranging with the Toronto General and the social service worker arranged for him to get his medications that way. But this is the way we had to go about to get it; it is a long, devious way, but that boy is being provided with drugs.



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J/MR/hm

MR. PRICE: You mentioned previously that you wouldn't leave any stone unturned to get medication for a patient. In some cases this involves discussions with one of these --

DR. CLARKSON: Social Service worker?

MR. PRICE: No, detail men. Do you find them co-operative?

DR. CLARKSON: Very, very co-operative.

MR. PRICE: In most cases?

DR. CLARKSON: Yes.

MR. PRICE: What cases? Could you give us any specific cases?

DR. CLARKSON: Yes. I had one patient that I wished to use an expensive type of drug on. I spoke to the detail man and he supplied me with a thousand capsules. This is good public relations.

MR. PRICE: What would the value be of these capsules?

DR. CLARKSON: When I say an expensive drug, I mean a capsule that is going to cost the patient 30¢ a day.

MR. PRICE: That might be expensive to one patient and it might not necessarily be expensive to someone else.

DR. CLARKSON: This was a person who couldn't afford medication.

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asked you. I don't think that it's only people who can afford to pay for the drugs that complain about the cost. In other words, I think the people who can well afford still complain about cost?

DR. CLARKSON: Oh I am sure they complain about the cost as they do about car costs too.

MR. PRICE: And possibly from your experience do you think it's because they don't understand?

DR. CLARKSON: Yes.

MR. PRICE: And perhaps it isn't explained to them why these pills are as expensive as they are.

DR. CLARKSON: That is right.

MR. PRICE: I think you mentioned previously that in some cases where this might come up you have a better opportunity of explaining to your patient why the cost is high and they accept it.

DR. CLARKSON: Yes.

MR. PRICE: I think a great many people don't have the opportunity of getting the answers and the result is they are under a misapprehension.

DR. CLARKSON: That is right.

THE CHAIRMAN: Dr. Clarkson, we have certainly appreciated hearing the information that you have been kind enough to bring here and tell us and the thought has occurred to me, there is a



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little different classification in that you have spoken of the case where there could be hardship. Are there any other cases of people who are retired and elderly who might have a reasonable amount of means but still they are unable financially to really carry that burden of prolonged use of drugs over a period of years and so while in the beginning they might be able to afford it, nevertheless it could over a period of years deplete their means quite considerably and eventually cause hardship.

Do you think that some system might be worked out where doctors could specify or collectively specify certain diseases in that type and once they were able to establish their qualification there might be an easier system where they could receive medication at a reduced rate, receive those drugs without having to search around, the same as you have been doing. I mean in rural areas and different places perhaps the medical profession doesn't know of the many ways that could be taken, and also in these cases the people might not fancy describing themselves as being in need or indigent, but if these chronic cases could be supplied drugs much more cheaply and more readily, do you think it would be practical at all to look towards that end? Perhaps through hospital dispensaries with a reasonable fee added; not that they should get the drugs free but at a lower rate than they would normally get them through the pharmacy.



DR. CLARKSON: Certainly I think if there is any way that can be taken in which some patients who are on medication can get it any easier way, I think this is a wonderful thing.

I feel that you would run into some very difficult snags with respect to who should get it and who shouldn't get it. I think this is the difficult problem. I think this is why the doctor himself who looks after the patient knows best. In the words of one of our practitioners who is an older man, he said "I have looked after this family now for 30 years and they have fallen on hard times. Don't you think I am going to look after them for nothing from here on in?"

THE CHAIRMAN: I can well understand that there could be difficulties but that was my thought that it wouldn't be who it should be but the type of illness or the type of medication should be the basis on which any effort might be made rather than on the question of who. I mean that was my thought there.

DR. CLARKSON: I don't think that that would work really sir. I don't think you could publish a list of diseases that should get medication in an easier way, I would say, because no list works.

In some places the person may have chronic bronchitis and may need the help, whereas in 70% of them they won't need the help. The patient



may have rheumatoid arthritis and may be 50% of them need help. This is your difficulty. It's judged on each individual patient. I think this is the difficulty that a Committee would have in appraising the cost of drugs because in medicine really we are dealing with individuals. We are not dealing with a group of people. We are not dealing with a type of person. We are dealing with a person who has an emotion, who has a family, who has children, who has expenses on one hand; others don't have and all these factors enter into the cost of drugs.

MR. TROTTER: Do you think, doctor, the situation could possibly be helped if they had a drug insurance scheme?

DR. CLARKSON: I think any insurance scheme that will help defray the cost of anything is good. I think it's a reasonable way of defraying the cost no matter what it happens to be. We do it with our cars and our books and everything else. We should do it with our health. I think that this is really good. I think it's a personal responsibility.

MR. TROTTER: Do you think the sympathy of the doctors in general and also pharmacists, because you are in some way dealing in a business, do you think they would be sympathetic to a scheme of insurance?

DR. CLARKSON: Yes, providing it didn't claim to pay everything. This is where it falls



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down. I think that if it was an indemnity type of insurance towards the cost of drugs, I think this would be a good thing.

THE CHAIRMAN: Any further questions?

MR. PRICE: Would you favour the government operating such a scheme for obtaining drugs?

DR. CLARKSON: Personally, no.

MR. TROTTER: Any objection why? What would be wrong with the government operating the scheme?

DR. CLARKSON: You are getting me into a corner here and I don't want to get into it.

MR. TROTTER: I won't push the subject at this point then.

MR. WREN: Of course, the British have discovered that they have had to institute a scheme of partial payment at least for their drugs and medication.

DR. CLARKSON: They have instituted one, yes.

MR. WREN: Where at one time they were entirely free they now have to pay a portion of the cost.

DR. CLARKSON: No comment sir.

MR. PRICE: I think Dr. Clarkson qualified his remarks when he said on a personal basis. If it's a personal basis it isn't on a government basis. In other words, the individual



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responsibility is for paying into some scheme a premium for something which is really prepaying on a personal basis, not quite on the same basis if the government had the scheme.

DR. CLARKSON: I don't follow you sir.

THE CHAIRMAN: Thank you very much Dr. Clarkson. We appreciate very much your information.

MR. RICE: We have also with us this afternoon Mr. Chairman, Dr. Bruce Halliday from Tavistock. Mr. Halliday? Would you state your full name sir?

DR. HALLIDAY: Bruce Halliday.

MR. RICE: And I understand you are a licensed medical practitioner?

DR. HALLIDAY: That is right sir.

MR. RICE: And where do you carry on your profession?

DR. HALLIDAY: In the village of Tavistock, Ontario.

MR. RICE: Could you tell us what the population of Tavistock is?

DR. HALLIDAY: The village itself is about 1,150 and the neighbouring townships would run somewhere in the range of 6,000 perhaps.

MR. RICE: And from what university did you graduate?

DR. HALLIDAY: University of Toronto.

MR. RICE: What year?



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DR. CLARKSON: I don't follow you sir.
THE CHAIRMAN: Thank you very much.

MR. RICE: We have said with us this
afternoon Mr. Chairman, Dr. Bruce Halliday, from
Tavistock, Mr. Halliday? Would you agree that this

DR. HALLIDAY: I agree with you.
MR. RICE: And I understand you are

a licensed medical practitioner?
DR. HALLIDAY: That is right sir.
MR. RICE: And where do you practice?

DR. HALLIDAY: I am at the
Tavistock Hospital.

MR. RICE: Could you tell us what the
population of Tavistock is?

DR. HALLIDAY: The village itself is
about 1,150 and the neighbouring townships would
run somewhere in the range of 6,000 perhaps.
MR. RICE: And from what university

did you graduate?
DR. HALLIDAY: University of Toronto.



DR. HALLIDAY: 1951.

MR. RICE: And after graduation did you do any post-graduate work?

DR. HALLIDAY: one year rotating internship at the Toronto Western.

MR. RICE: Do you specialize in any branch of medicine?

DR. HALLIDAY: No, I do general practise.

MR. RICE: Have you any prepared statement that you wish to present to the Committee?

DR. HALLIDAY: No, I do not.

MR. RICE: I take it in the course of your general practise you also prescribe drugs for your patients?

DR. HALLIDAY: I work with a group of four. There are four of us in partnership. We have our own dispensary. We write very few prescriptions that we don't fill ourselves.

MR. RICE: In the group of four that you are in partnership with do you practise medicine with them in the same location?

DR. HALLIDAY: We are in a very intimate partnership.

MR. RICE: Who operates your dispensary, if you have any?

DR. HALLIDAY: We operate as a group.

MR. RICE: You do not have any pharmacists, or anyone --

DR. HALLIDAY: We have -- one of our partners is a graduate pharmacist, actually.



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MR. RICE: And where do you purchase the drugs for your dispensary from?

DR. HALLIDAY: We endeavour to purchase most of our drugs direct from the company that manufactures the drug.

MR. RICE: And what discount are you able to purchase these drugs from the manufacturer at?

DR. HALLIDAY: I would say the average discount is about 40%, although if we buy in very large quantities that will be better at times.

MR. RICE: How many different drugs would you carry in your dispensary?

DR. HALLIDAY: I am sorry, but I couldn't give you an exact estimate of the number. I can say that we have an inventory of about \$6,000.00.

MR. RICE: What would be your annual turnover in your dispensary?

DR. HALLIDAY: I think in the neighbourhood of twenty-five to thirty thousand.

MR. RICE: Twenty-five to thirty thousand?

DR. HALLIDAY: Yes.

MR. RICE: Just from the dispensary alone?

DR. HALLIDAY: Yes.

MR. TROTTER: Is this numbers or dollars?



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MR. RICE: And what discount are you

able to purchase these drugs from the manufacturer

DR. HALLIDAY: I would say the average

discount is about 40%, although if we pay in very

large quantities that will be better at times.

MR. RICE: How many different drugs

would you carry in your dispensary?

DR. HALLIDAY: I am sorry, but I

couldn't give you an exact estimate of the number.

I can say that we have an inventory of about

MR. RICE: What would be your annual

turnover in your dispensary?

DR. HALLIDAY: I think in the neigh-

borhood of twenty-five to thirty thousand.

MR. RICE: Twenty-five to thirty

thousand?

DR. HALLIDAY: Yes.

MR. RICE: Just from the dispensary

alone?

DR. HALLIDAY: Yes.

MR. TROTTER: Is this numbers or



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DR. HALLIDAY: Dollars, I am sorry sir.

Those are dollars.

MR. RICE: And approximately how many prescriptions would that be dispensed out of your dispensary?

DR. HALLIDAY: I can't give you that figure. We don't actually write a prescription. We just keep a record on the patient's history card of what they have got on each visit and we don't total those up at all.



Halliday

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DR. HALLIDAY: Gollars, I am sorry sir.

prescriptions would that be dispensed out of your

DR. HALLIDAY: I can't give you that

just keep a record on the patient's history card of
what they have got on each visit and we don't total
those up at all.



/dpw

MR. RICE: Do you dispense drugs to anyone who has a prescription, or only to your own patients?

DR. HALLIDAY: Just our own patients.

MR. RICE: How do you account, or how do you charge your patient for these prescriptions?

DR. HALLIDAY: We charge them as a rule approximately the list price. There is no dispensing added, although if we come down on a Sunday or make a special trip just to get pills, we may add 25 cents or 50 cents.

MR. RICE: That is the manufacturer's list price?

DR. HALLIDAY: Yes.

MR. RICE: Do you use the method as prescribed by the Ontario College of Pharmacy?

DR. HALLIDAY: By that you mean?

MR. RICE: For prescribing, they have a method I understand?

DR. HALLIDAY: We don't follow that exactly, no, I think my associate is familiar with it.

MR. RICE: Generally it is the manufacturer's list price that you use?

DR. HALLIDAY: That is right.

MR. WREN: Is your associate both a medical doctor and a pharmacist?

DR. HALLIDAY: That is right sir, he



MR. F. G. G. Do you have a license to
anyone who has a license to, or only to your own
patronage?

DR. HALLIDAY: I have one license.

MR. F. G. G. How do you account for
how do you change your position for these questions?

DR. HALLIDAY: The change there is a
two approximately the last time, there is no
degenerating about, at least, if we come down to a
Gandy or make a special time to do this
we may add 25 cents or 50 cents.

MR. F. G. G. What is the reason for this?

DR. HALLIDAY: Yes.

MR. F. G. G. Do you use the method as
prescribed by the Ontario College of Pharmacists?
DR. HALLIDAY: Yes, but you know
MR. F. G. G. How prescribed are they?

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MR. HALLIDAY: We don't follow that
exactly, no, I think the schedule is similar with

MR. F. G. G. Generally it is the same.

factor's list price that you use.

DR. HALLIDAY: That is right.

MR. W. W. W. Is your association with a

medical doctor and a pharmacist?

DR. HALLIDAY: That is right, sir, he



is. I might add that he took pharmacy first and didn't like selling all the sundries that the pharmacist sold, and went into medicine instead. He is much happier.

MR. RICE: Do you purchase, or carry your drugs by the generic or the trade, brand name?

DR. HALLIDAY: We have some of both, and we endeavour to order those drugs which we think will serve the patient best, both from the point of view of quality of the drug, and of price, and I might anticipate another question of yours, having sat here, and I think it is a term of reference of your Committee, I think one of the best things you can do is to clarify and reconcile the difference in price that does exist between some of the trade names and some of the generic names of the same products, and endeavour to elucidate whether those two tablets, one by trade name and one by generic name, have the same qualities, and we are at a loose end to know whether to buy a trade name at 15 cents when we can buy the very same pill for 5 cents. That is, buy for 5 cents and sell for 15 cents, and we would appreciate having somebody tell us whether those two pills are the same.

MR. WREN: The same quality you mean?

DR. HALLIDAY: Yes, we know there is a difference in price.

MR. TROTTER: When you want to find out about a new drug, how do you find out about it,



is. I might add that he took personally this and didn't like selling all the material that the place that sold, and went into with the material. He is much happier.

MR. BROWN: Do you understand, or carry your goods by the generic or the trade, brand name?

MR. HALLIDAY: We have some of both.

and we emphasize no order of the kind which we think will serve the patient best, from the point of view of quality of the drug and of price. and I might anticipate another question of yours, having said here, and I think it is a term of reference of your Committee, I think one of the things you can do is to clarify and reconcile the difference in price that does exist between some of the trade names and some of the generic names of the same products, and emphasize no elaborate whether those two tablets, one by trade name and one by generic name, have the same quality, and we are at a loss even to know what to pay a trade name at 15 cents when we can buy the very same pill for 5 cents. That is, pay for 5 cents and sell for 15 cents, and we would appreciate having somebody tell us whether those two pills are the same.

MR. WILSON: The same quality, you mean?

MR. HALLIDAY: Yes, we know there is a difference in price.

MR. TROTTER: When you want to find out about a new drug, how do you find out about it?



its quality for one thing?

DR. HALLIDAY: Well, we don't doubt the quality of the drugs produced by the well-established firms such as Parke Davis, and I could name a dozen or more. We don't doubt those drugs at all. We have some doubt put into our minds by the salesmen of those companies that the generic drug comparable to what they produce is not as good.

We do subscribe to the medical letter which you heard about today. I personally put a lot of faith in the opinions expressed there, I think they are very unbiased. I am familiar with the consumer report, and I think that anything that comes out in the medical letter when they analyse and compare the trade names of the same generic drug, I have my faith in that.

MR. RICE: Do you have any separate way of accounting for your dispensary from the rest of your business, so that you could determine whether or not your dispensary is making a profit, or operating in the red?

DR. HALLIDAY: No, we cannot be definite about that. We assume we are making a profit. Three years ago we put in a National Cash Register bookkeeping machine which itemizes our accounts as to house-calls, office calls, medications, and so on, and we could add up what is on the books for medications.

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MR. EISEN: Do you have any separate
way of accounting for your discrepancy from the rest
of your business, so that you could determine
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MR. EISEN: Would there be any way of



applying a percentage of overhead to it, to determine whether or not it would be profitable in that sense?

DR. HALLIDAY: We just have the impression it is profitable. We have no figures to prove it.

MR. RICE: Do you plan to continue with it?

DR. HALLIDAY: Yes.

MR. RICE: Are there any retail drug outlets in Tavistock?

DR. HALLIDAY: There is one graduate druggist who has a store in town. He does not stock the usual drugs we dispense, but more the patent medicine type thing, and other incidentals a drug-store carries. He will buy anything we suggest.

MR. RICE: Do you ever purchase drugs from a retail outlet?

DR. HALLIDAY: Yes we do.

MR. RICE: Do you get any discount?

DR. HALLIDAY: On an average, about 25%.

MR. RICE: Is that 25% off the manufacturer's list price, or off the retail price?

DR. HALLIDAY: Off the manufacturer's list price.

MR. WREN: That is when you buy them to be re-dispensed?

DR. HALLIDAY: Sometimes we cannot buy direct from certain companies, and we can buy



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DR. HALLIDAY: Sometimes we cannot buy direct from certain companies, and we can buy



that same product from a retail druggist, who will give us 25% off the manufacturer's list, and then we dispense it.

MR. RICE: Have you ever had any complaints from your patients regarding the prices they have to pay for prescriptions?

DR. HALLIDAY: We do at times, but I agree with Dr. Clarkson that if you take the time to explain why he needs that drug and so on we have no particular complaints.

MR. RICE: Do you feel that it is a general lack of understanding on the part of the patient as to how his invoice is composed, what goes into it?

DR. HALLIDAY: I would agree with that.

MR. RICE: Have you had any complaints from the retail pharmacists in the area about you operating your dispensary at the prices you do?

DR. HALLIDAY: Well, our retail pharmacist does not dispense. The closest one that does would be about 10 miles away, and we have no complaints from them that I am aware of.

MR. RICE: Do you also compound drugs in your dispensary?

DR. HALLIDAY: We don't compound any tablets. Sometimes a bottle of medicine, but that is getting to be fewer and fewer, because more and more are being compounded by the manufacturers.

MR. TROTTER: What do you do with the



that same product from a retail druggist, who will give us 25% off the manufacturer's list, and then we

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more are being compounded by the manufacturers.

MR. THORNTON: What do you do with the



samples you receive from the drug companies?

DR. HALLIDAY: It depends what it is. If it is something that we stock regularly, we put those samples in our stock, the reason being, and I think we have a clear conscience on that, that we dispense our tablets to anybody, whether they can afford to pay or not, and we fully realise that sometimes we are not going to get paid for something we dispense, and we feel that though in essence we are selling samples, in actual fact we are giving them to somebody.

MR. TROTTER: Do very many of the samples get into the garbage can?

DR. HALLIDAY: No, the ones we don't have much use for, a neighbouring church body collects them, and they are sent to India or Africa or some such place. We throw nothing out.

MR. RICE: How do you determine what drugs to stock in your dispensary?

DR. HALLIDAY: By mutual agreement between the four of us.

MR. RICE: How do you determine what manufacturer these drugs should come from?

DR. HALLIDAY: That is where we would like some help from you people in future. If you have doubts about the quality of the products we buy from the manufacturer, we feel pretty certain he would give us good quality.

MR. WREN: Do you think a public



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like some help from you people in future. If you have doubts about the quality of the products we buy from the manufacturer, we feel pretty certain he would give us good quality.

MR. WREN: Do you think a public



analyst would be helpful?

DR. HALLIDAY: Yes, that is a good thought.

MR. WREN: It was suggested yesterday that perhaps the regional board should carry an analyst on its staff.

DR. HALLIDAY: I understand the federal department has a branch to see that drugs are up to standard, but from what I am told by detail men they are most inefficient, and don't get around to sample drugs from smaller companies sufficiently often. That is the story from the larger companies, and of course the smaller companies have a different story.

MR. WREN: We have heard of occasions when the smaller companies are very well checked.

DR. HALLIDAY: That could be.

MR. WREN: Do you carry any alcoholic liquor in your dispensary, for dispensing I mean?

DR. HALLIDAY: We might carry tonics or elixirs as high as 18%.

MR. WREN: Do you purchase that from the Liquor Commission?

DR. HALLIDAY: No, from the drug house.

MR. WREN: I am just interested in their discount.

DR. HALLIDAY: Sorry.

MR. RICE: When one of your group makes a prescription for a patient, do you give



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MR. WHEAT: Do you carry any alcoholic

liquor in your dispensary, for dispensing I mean?

DR. HALLIDAY: We might carry tonics

or elixirs as high as 10%.

MR. WHEAT: Do you purchase that from

DR. HALLIDAY: No, from the drug

house.

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MR. RICE: When one of your group

makes a prescription for a patient, do you give



any indication as to where that prescription is to be filled?

2 DR. HALLIDAY: We don't write a prescription. We just write down the name of the drug and the number of the tablet to be dispensed, and the directions, and give them the tablets. If they prefer to buy them somewhere else, we will give them a prescription, but they find out that prices are higher somewhere else.

THE CHAIRMAN: Have you at any time purchased a drug that later on you have reason to believe may not have been up to the required standard?

DR. HALLIDAY: The only thing I can think of is that sometimes the coatings on some tablets from a small company won't stand up as well, but we can send them back and be fully recompensed. We never have any criticism with a large company such as Parke Davis, but occasionally from the smaller companies.

THE CHAIRMAN: You have had no experience of any ill side effects from anything of that kind from a patient?

DR. HALLIDAY: Not that I am aware of, no.

THE CHAIRMAN: Earlier today, the previous witness suggested that the constancy of a drug might vary from one tablet to another, or in the dose. Have you had any experience that would



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previous witness suggested that the constancy of a
drug might vary from one tablet to another, or in
the dose. Have you had any experience that would



suggest that some of the drugs by generic names might fall short in that regard, or do you think that pretty well even the smaller drug companies, that their drugs are pretty well of a consistent standard as far as the composition is concerned?

DR. HALLIDAY: I think we have no way of assessing that question accurately. If you take the cortisone type of drug, we have stocked recently some white and some pink varieties, made by different companies, and people say the pink is a lot better than the white. We have had brown and pink aspirin tablets in the office, and we have had people from one company swear that one colour is perfect and the other colour is no good.

MR. BOYER: If you discover any unusual effect from a drug, do you discuss that with the manufacturer?

DR. HALLIDAY: Usually any effects are well documented in the literature, and we expect to find it and accept that as a well-established fact.

MR. RICE: Would you agree with Dr. Fallis that there are about 10 or 12 drugs that are more commonly prescribed than the others?

DR. HALLIDAY: I would be more inclined to agree with Dr. Clarkson, that it is more in the range of 25, 30.

MR. RICE: Are there any recommendations you could make to the Committee as to how this Committee could lower the cost of drugs?



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DR. HALLIDAY: I intimated previously that a real service you could do would be to reconcile these differences in price and quality between certain trade names and generic names.

MR. RICE: You have no other recommendations you would like to make, other than that?

DR. HALLIDAY: You have discussed previously the problem of advertising that comes through the mail. I agree with Dr. Clarkson that most of it should be thrown in the wastepaper basket. I look at each piece, but generally only for a few seconds.

MR. TROTTER: Do you have any hardship cases down your way, where people find it difficult to pay for drugs?

DR. HALLIDAY: Yes, and we have no clinic to take care of it, and take it on ourselves as a rule.

MR. TROTTER: Do you find the cost on the four doctors great?

DR. HALLIDAY: I was interested in Dr. Clarkson's statement that they established a cash-and-carry policy with their drugs. We don't do that, although we would be much better off financially if we did, but we feel it would be a hardship on some people.

MR. TROTTER: Would you be opposed to having drugs covered by an insurance scheme?

DR. HALLIDAY: I think insurance is



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Halliday

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much as we find now that the policies in ordinary
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You have to pay a deductible on windshields for
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too, because I feel personally that it would be
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 awful lot of expense.

THE CHAIRMAN: In your opinion the first payments would have to be paid by the patient up to a certain sum of money, and then anything beyond that he could receive compensation from the insurance scheme?

DR. HALLIDAY: I would be more inclined to agree with that type of scheme.

THE CHAIRMAN: Would you agree with Dr. Clarkson in his remark that in his opinion it would be impossible for any plan to work out where certain types of chronic cases could be designated and a specific effort made to assist those people by providing them with drugs at lower costs than they would normally be able to obtain them?

DR. HALLIDAY: I would agree that would be difficult. Mind you, there are certain drugs that people in difficulty can get. Diabetics who have no means, they can get the insulin they need free from the community. The individual who has cancer can get any of the expensive medications free now from the Cancer Society, so gradually that category is being narrowed down to a smaller and smaller group of people.

THE CHAIRMAN: Yes, I see.

MR. WREN: I can assure you some of these societies, cancer and arthritic and some of the others, they do not extend the kind of assistance that a lot of people believe they do. A great deal of their activity is taken up with administrative



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costs.

DR. HALLIDAY: That is true of any type of insurance scheme.

MR. TROTTER: I won't argue that point, but I would disagree with that.

MR. WREN: I have had experience with it a good deal. For example, in arthritic cases, and I am speaking of Northern Ontario, can appeal to the Arthritic Society, and ends up with endless red tape and very little assistance. They will refer you to all kinds of people, but I am talking now about direct assistance.

DR. HALLIDAY: I see.

MR. RICE: Can you file with the secretary the list of the twenty-five more common prescribed drugs that you prescribe, and present it by mail?

DR. HALLIDAY: By mail?

MR. RICE: Yes.

DR. HALLIDAY: I would be glad to. Do you want the generic name or the trade name we use?

MR. RICE: Whichever name you prescribe.

DR. HALLIDAY: Yes. I will be glad to.

MR. RICE: And would you also put the cost that you charge the patient or the charge to your dispensary?

DR. HALLIDAY: The price we sell them at?

MR. RICE: Yes. What you pay for them



Halliday

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MR. RICE: Yes. What you pay for them



and what you sell them at?

DR. HALLIDAY: Yes.

MR. RICE: Are there any other questions, Mr. Chairman?

MR. PRICE: If you were to buy, Dr. Halliday, some tablets from a retail store, you get a reduction of 25%?

DR. HALLIDAY: Yes.

MR. PRICE: If you are going to re-dispense those, would you charge the patient your cost plus the fee, I suppose?

DR. HALLIDAY: We just put on that 25%.

MR. PRICE: They would pay more from you than if they had bought them from the retail store?

DR. HALLIDAY: No, they would pay less. If the list price is a dollar for a tablet, and we buy them from the druggist at 75¢ we will dispense them for a dollar, and that same druggist probably dispenses at \$1.75.

MR. PRICE: Is it your opinion that the cost of drugs is not too high?

DR. HALLIDAY: I think I would agree with the previous two speakers that mainly it is a lack of understanding between the patient and the pharmaceutical houses and the doctors about the price of these drugs. I still think we have to explain the discrepancy between a tablet that is



Halliday

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and what you sell them at?

DR. HALLIDAY: Yes.

MR. PRICE: Are there any other indications?

MR. PRICE: If you were to say, Dr.

Halliday, some tablets from a retail store, you get

a reduction of 25%?

DR. HALLIDAY: Yes.

MR. PRICE: If you are going to re-

disappear these, would you observe the retention point

cost plus the fee, I suppose?

DR. HALLIDAY: We just put on that

MR. PRICE: They would pay more from

you than if they had bought them from the retail

store.

DR. HALLIDAY: No, they would pay less.

If the list price is a dollar for a tablet, and we

only them from the drugist at 75¢ we will disappear

them for a dollar, and that same drugist probably

disappears at 25¢.

MR. PRICE: Is it your opinion that

the cost of drugs is not too high?

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lack of understanding between the patient and the

pharmaceutical houses and the doctors about the

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put on the market originally by a company and lists let us say at 15¢, and the same tablet which may be bought by the generic name, that lists at 5¢. If the 5¢ tablet is as good as the 15¢ tablet, I would guess the 15¢ tablet is too much.

MR. PRICE: We have heard of some cases where they might even be better although cheaper. Do you have any knowledge of how drugs are tested by the manufacturer before becoming available to the public?

DR. HALLIDAY: I have had the privilege of touring Parke-Davis as most medical students have, and we were all very impressed with their methods there, but we have no means of comparing their methods with any other company.

MR. PRICE: How are they actually tested to get this information that the detail men pass on to you before becoming available to the public? How do they ascertain that these drugs are useful and that they will do a job?

DR. HALLIDAY: As I understand it, they take certain lots, a certain number out of any lot of tablets or whatever product it is we are concerned with, and they analyze that particular tablet and see whether it meets up with the standard they expected it to have.

MR. PRICE: Are they tested on patients before they become available to the general public?

DR. HALLIDAY: I am sorry, I misunderstood.



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Yes, I believe all such new products undergo extensive tests, very controlled tests, usually through the teaching hospitals before they put on sale to the general public.

MR. PRICE: Have you had any experience of observing at a teaching hospital where they are making such experiments?

DR. HALLIDAY: Just as a junior intern. It is very limited.

MR. PRICE: What hospital in Toronto might be carrying out some of these tests?

DR. HALLIDAY: Well, I think four or five teaching hospitals, General, Western, St. Mike's, and perhaps Sick Children's. Those four would be carrying on. That is for certain.

MR. PRICE: Do the manufacturers provide these drugs free while these experiments are going on to the hospitals?

DR. HALLIDAY: I am getting a little bit out of my depth, but I would presume they do though. I am quite sure.

MR. WREN: In your training in university during your own experience of course in pharmacy, do you take as much training as a pharmacist would in that field or more or less?

DR. HALLIDAY: We have a course that I believe occupies one year in pharmacy. It is called pharmacy. Mind you, we take all the pre-requisite biochemistry and organic chemistry which



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occupies a lot of the time of the pharmacy course itself.

I believe I am correct in saying that a graduate doctor is legally qualified to dispense.

MR. WREN: Oh, I know he is legally qualified, but does he get more training in pharmacy or less than a pharmacist?

DR. HALLIDAY: We get very little training in compounding tablets and compounding medicines, but we don't do much of that.

I think it is unfortunate the way the pharmacy profession is moving, and I note in the Globe and Mail about two days ago that there was a suggestion made that there should be an effort to get pharmacists to stick more to their profession of pharmacy and spend less time on the retail sale of sundries.

I find myself when I discuss certain tablets or medication with a graduate pharmacist, they don't know much more about it and even less than I do. I ask for a tablet and they don't know what I am talking about, and I have to explain to them what it is and who makes it because they are getting out of touch.

MR. WREN: Were these recent graduates?

DR. HALLIDAY: Not necessarily recent.

MR. WREN: You see, the fact is we have been told they take four years in university



plus eighteen months' apprenticeship, and what does a doctor have?

DR. HALLIDAY: Six years.

MR. WREN: Which entails a good deal more than the pharmacist?

DR. HALLIDAY: Yes. Oh, yes.

MR. RICE: Are there any other questions?

THE CHAIRMAN: Thank you very much, Dr. Halliday. I am sure we have appreciated the information you have given us, and we understand you will be sending further material to our secretary.

DR. HALLIDAY: I shall address that to whom?

MR. GADSBY: I will give you that.

MR. RICE: We also have this afternoon, Mr. Chairman, Dr. Gordon Judge of Burford. Would you tell us what your full name is, please?

DR. JUDGE: Gordon Albert Judge.

MR. RICE: I understand you are a licensed medical practitioner?

DR. JUDGE: Yes, sir.

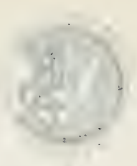
MR. RICE: Where do you carry on your profession?

DR. JUDGE: Burford.

MR. RICE: Would you tell us what the population of Burford is?

DR. JUDGE: About 1,000.

MR. RICE: Do you also attend the surrounding area?



a doctor have?

MR. HALLIDAY: Six years.

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more than the pharmacist?

MR. RICE: Are there any other questions?

THE CHAIRMAN: Thank you very much.

Dr. Halliday, I am sure we have appreciated the information you have given us, and we understand you will be sending further material to our secretary.

MR. HALLIDAY: I shall correct that

to whom?

MR. RICE: I will give you that.

MR. RICE: We also have this afternoon.

Mr. Chairman, Dr. Gordon Judge of Bedford. Would you

tell us what your full name is, please?

DR. JUDGE: Gordon Albert Judge.

MR. RICE: I understand you are a

licensed medical practitioner?

MR. RICE: Where do you carry on your

MR. RICE: Would you tell us what the

population of Bedford is?

DR. JUDGE: About 1,000.

MR. RICE: Do you also spend the



DR. JUDGE: That is right, sir.

MR. RICE: What would that population be?

DR. JUDGE: It is impossible to tell you the surrounding area I cover in population. Two doctors of the village have guessed we perhaps cover a population of about 5,000 total.

MR. RICE: Do you practise your profession in partnership with anyone else?

DR. JUDGE: No, just myself.

MR. RICE: From what university did you graduate?

DR. JUDGE: Queen's.

MR. RICE: What year?

DR. JUDGE: 1950.

MR. RICE: Did you do any post-graduate work?

DR. JUDGE: Junior internship.

MR. RICE: Have you practised anywhere else other than Burford?

DR. JUDGE: Yes, I practised for a time in Saskatchewan.

MR. RICE: I see that in the course of your profession you also prescribe medicines do you?

DR. JUDGE: Yes, sir.

MR. RICE: Could you give any assistance on how many prescriptions you would write in a year or a month?



MR. RICE: What would that population

be?

DR. JUDGE: It is impossible to tell.

For the surrounding area I cover in population. Two doctors of the village have guessed we perhaps cover a population of about 2,000 total.

MR. RICE: Do you practise your profession

in partnership with anyone else?

DR. JUDGE: No, just myself.

MR. RICE: From what university did

you graduate?

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write in a year or a month?



DR. JUDGE: I don't really know. I will explain to you what I do, and then we can go on from there. I do dispense a little bit. A share of the drugs I use are on prescription. I would think that I probably issue about 25 or 30 prescriptions a week, but it is difficult to check that because they would go to many pharmacies, and the only record would be on the patient's case history actually.

MR. RICE: Have you any prepared statement you wish to make to the Committee this afternoon?

DR. JUDGE: No, sir.

MR. RICE: You do some dispensing yourself?

DR. JUDGE: A small amount.

MR. RICE: Could you tell us what the value of the drugs in your dispensary would be?

DR. JUDGE: Perhaps \$1,000.00.

MR. RICE: What would be the yearly turnover in your dispensary in value?

DR. JUDGE: Just currently I am not quite sure. It has ranged from \$1,000.00 to \$1,500.00.

MR. RICE: Where do you purchase the drugs you dispense?

DR. JUDGE: Usually from one of two or three small manufacturers, drug manufacturing companies.

MR. RICE: Do you purchase these under their generic name or trade name?



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DR. JUDGE: Partly both, I suppose, because some small manufacturers have their own brand names, you know, and they don't necessarily just stick to the generic name. Essentially -- and I think I had better clear the air -- now this can be embarrassing for my practise at home in telling you what I am going to say, but I will take that chance.

The things that I keep in my office to dispense myself are there for one of two or three reasons. They are very, very cheap items. An example would be phenobarb which one could purchase at a great many places at a very, very low price. One sees in practise quite a lot of phenobarb. If I were to write prescriptions for that, I would find the patient was paying many, many, many times the cost of that actual drug in order to have my prescription filled.

For that reason I give those tablets to the patients in actual fact. It is a lot easier really. I suppose that is not quite ethical, but in actual fact I give them away. I don't make any charge for those.

If the patient came back for a refill of those tablets without making an office call and with no house call involved, perhaps I would charge for the tablets.

Now, I keep only a very limited group of drugs of that sort, and then there is the other group of drugs which I keep, and this is the part that might be embarrassing, but I think all doctors





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are willing to admit this that certain patients require placebos. In rural Ontario habits have been built up. The elderly patient, if he came to my office in a rural community and he wouldn't -- many of those wouldn't pay the service to me. They never have. They have grown up with the idea they go and see the doctor and have a friendly little chat and they buy a few pills or a bottle of medicine from him. Now, there are a few of those people still existing. One has to treat them kindly, and I have a certain number of preparations of that sort that I issue to them.



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few of these people still existing. One has to treat
them kindly, and I have a certain number of preparations
of that sort that I have to hand.



/dpw

Now, as I said, that is a rather embarrassing sort of thing to send back to a community where we have to treat these people.

MR. BOYER: Many people have suspected that. I don't think you have to worry.

DR. JUDGE: It depends which ones suspect it.

MR. PRICE: I was going to ask what you do with your samples. Frankly, I think you have to be commended for the action you are taking with these patients. After all, it is a great waste to throw them in the garbage.

DR. JUDGE: I am sorry, did I give the impression that I was handing out samples in that way?

MR. RICE: When you are purchasing your drugs do you find there is a great difference in price between manufacturers for similar drugs?

DR. JUDGE: Not in the kind of drugs I buy, no, because I am buying a pretty old standard preparation. Phenobarbital is a pretty old preparation, aspirin, A.P.C. and C.'s.

MR. RICE: I take it you don't have much difficulty in picking out which manufacturer to purchase from?

DR. JUDGE: No, I haven't noticed any particular difference, except that occasionally some manufacturers in the detail, technical detail, its physical characteristics may vary in quality.



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I don't imagine that the ingredients vary enough to matter. I don't have any proof, but I have no reason to believe it.

MR. RICE: When you purchase from a manufacturer what price do you purchase at?

DR. JUDGE: That depends on the manufacturer. There are some manufacturers that sell only to doctors in Ontario, at least largely to doctors. I don't think they sell much to retail pharmacists. Those companies usually don't have anything but a price they quote me. Some of the larger and more sophisticated companies have a 40% discount, which is standard, when you buy large quantities of tablets or medicine.

MR. RICE: When you are prescribing for your patients, and so on, how do you charge for the drugs?

DR. JUDGE: When I am dispensing?

MR. RICE: Yes.

DR. JUDGE: I make no separate charge at all, unless it is a repeat of a preparation where there is no office call involved. If there is an office call involved I do not normally charge for the drug. The only time I would do that is when I am buying some expensive drug for a specific patient with a long-term illness, where it would be a separate item and in isolated circumstances.

MR. RICE: In those circumstances



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what would you charge?

DR. JUDGE: I would charge precisely what I pay for it.

MR. RICE: On these repeats without an office call, how would you charge there?

DR. JUDGE: It depends on the number of tablets involved. I would rather make a standard of the number of tablets I gave with an office call. Generally speaking it is a flat rate of a dollar.

MR. RICE: Is it all-inclusive regardless of the cost of the drugs?

DR. JUDGE: It is just a dollar, regardless of the cost of drugs, because I am not stocking drugs which are expensive.

MR. RICE: How many pills would there usually be in this dollar value?

DR. JUDGE: It varies. It may be anything from a dozen A.P.C. and C.'s to a couple of hundred phenobarbital, depending on how I can trust the patient and what he needs them for.

MR. RICE: What would be the average cost to you for a dollar?

DR. JUDGE: The bare cost of the drug of the order of 25 cents, not including my time, supplying envelopes or bottles or anything of that sort.

MR. RICE: Have you had any complaints to you from your patients about the costs



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they have to pay for prescriptions?

DR. JUDGE: Yes, I have a certain number of complaints of that sort.

MR. RICE: And would you agree with the previous witnesses that it is due to lack of understanding and knowledge on the part of the patients as to how the cost is compiled?

DR. JUDGE: I think so, yes. In my practice I do not direct, I wouldn't think of directing where a patient takes a prescription. I find they do the usual thing, checking on the price of a prescription, check with what they think is a similar prescription in Brantford, and that is usually where the difficulty arises, where they think they are comparing the same thing. Most of our comparisons have been between the village drugstore and a city drugstore. Where there is a complaint is usually where the drug has failed to do what was expected. We hope we have these things explained to our patients sufficiently well, but sometimes we get too busy to explain them all.

MR. RICE: Have you ever prescribed to your patients any prescription of a higher priced drug which you do not carry and they have to go to the retail store?

DR. JUDGE: Most of the drugs we use are from a retail store.

MR. RICE: Have you ever had any



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to your patients any prescription of a higher

priced drug which you do not carry and they have

to go to the retail store?

DR. JONES: Most of the drugs we

use are from a retail store.

MR. RICE: Have you ever had any



invoices from the retail store where you consider they are high, the cost?

DR. JUDGE: I don't know whether they are excessive or not. I have no way of knowing really. I am aware that the druggist has fixed costs which he can't avoid, and on several occasions I discuss it with them. I do know there can be quite a variation in the price of the preparation. If it is available under a generic name and you can assure yourself that the generic name drug is going to be supplied. But it strikes me there is some misconception about this generic name situation. Everyone has been asking doctors to use generic names in their prescriptions, which is justified. The patients ask me to write a prescription for the cheapest possible drug. If I write the generic name for the drug, then at that point what it is filled with is entirely up to the pharmacist, and there is no legal reason or moral reason that I know of for not supplying a brand name variety for that generic name drug. I have asked for that, and whether I call it by its brand name or generic name matters not at all. If I write for a brand name, then I have no choice, I must have that name, but if it is a generic name he can supply that high-priced preparation.

MR. RICE: Then in those circumstances it would be up to the pharmacist if there is going to be any price reduction or saving to the patient.



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but if it is a generic name he can supply that

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MR. RICH: Then in those circumstances

it would be up to the pharmacist if there is going

to be any price reduction or saving to the patient.



DR. JUDGE: Yes; and you must look at it from the pharmacist's point of view for half a minute, too, because there are mark-ups in the pharmacy, there is the dispensing fee of 75 cents or a dollar or whatever is customary in the community, and so on. If he has a choice between a drug that he buys for one cent per tablet and a drug he buys for 10 cents per tablet, if he stuck to the strict formula of 40% he would make more profit if he sold the expensive drug. I am just picturing a situation we are opening up.

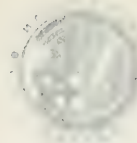
MR. BOYER: Would there be a difference in a product between a one-cent tablet and a 10-cent tablet?

DR. JUDGE: I have no way of knowing, as the previous witnesses have stated. I subscribe to the Medical Letter, I have seen their comparison of the various drugs in the United States, and in some cases the cheap drug is inferior and in some cases the more expensive drug is inferior, very often.

MR. PRICE: Do you prefer brand name drugs?

DR. JUDGE: Not specifically. I prefer a brand name drug to a tongue-twister of a generic name, yes, but that has nothing to do with prices.

MR. RICE: Qualitywise, have you noticed yourself in your own business where a



DR. JUDGE: Yes; and you must look at

it from the pharmacist's point of view for half a

minute, too, because there are mark-ups in the

pharmacy, there is the dispensing fee of 15 cents

or a dollar or whatever is customary in the commu-

nity, and so on. If he has a choice between a

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drug he pays for 10 cents per tablet, if he sticks

to the strict formula of 40¢ he would make more

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generic name, yes, but that has nothing to do with

prices.

MR. PRICE: Qualitatively, have you

noticed yourself in your own business where a



patient has perhaps used one of these cheaper generic name drugs and another patient has used a more expensive brand name any reaction?

DR. JUDGE: One cannot compare that in private practice where there is no control, where you are dealing with people and emotions, and so on. Colours of tablets and medicines, the colour was very important in medicine a way back - never prescribe a blue medicine. Now a lot of companies make blue medicine.

MR. TROTTER: Doctor, can you tell us - and there again it would be the same question the other doctors were asked - about the samples you receive and literature you receive from manufacturers?

DR. JUDGE: As far as samples are concerned. A fair number of samples I give to indigents or to individuals who are in difficulty one way or another. If I can help them out I do. I try to keep some semblance of order in the samples that arrive. Certain of the samples I don't know what to do with.

MR. TROTTER: You put them in the garbage can?

DR. JUDGE: I burn them. Many of them are a menace, and many of them are a combination of things which I can't figure out myself, and I don't care to give them to anyone else to try to figure out.

MR. TROTTER: What percentage of

patient has perhaps used one of these cheaper generic
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sive brand name any reaction?

DR. JUDGE: One cannot compare that in

private practice where there is no control, where
you are dealing with people and emotions, and so on.

colours of tablets and medicines, the colour was
very important in medicine a way back - never pres-
cribe a blue medicine. Now a lot of companies make
blue medicine.

MR. TROTTER: Doctor, can you tell us

- and there again it would be the same question the

other doctors were asked - about the samples you
receive and literature you receive from manufacturers?

DR. JUDGE: As far as samples are

concerned. A fair number of samples I give to indi-

vidents or to individuals who are in difficulty one

way or another. If I can help them out I do. I

try to keep some semblance of order in the samples

that arrive. Certain of the samples I don't know

what to do with.

MR. TROTTER: You put them in the

DR. JUDGE: I burn them. Many of

them are a menace, and many of them are a combina-

tion of things which I can't figure out myself,

and I don't care to give them to anyone else to

try to figure out.

MR. TROTTER: What percentage of



samples would be burned or destroyed?

DR. JUDGE: About half probably.

MR. TROTTER: What about the literature you receive from the drug companies?

DR. JUDGE: Could I amplify on what I said about the half?

MR. TROTTER: Yes.

DR. JUDGE: There are two ways of receiving those samples. One is that they come through the mail, and a rather high percentage of those through the mail are destroyed. The samples I receive from the detail man usually I refuse to take.

MR. TROTTER: What about the literature you receive from the drug companies?

DR. JUDGE: Well, there are terms for that. Most of it is an insult to the intelligence. It is gaudy, it doesn't say very much, and if you were to pay too much attention to it you would be misled, because, after all, it is selling something. I don't put any faith in most of it at all.



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V/MR/hm

MR. TROTTER: Do you have any hardship cases in your area, that is hardship cases in respect to where people can't afford to pay for drugs?

DR. JUDGE: Yes, a certain number.

MR. TROTTER: How do you take care of them?

DR. JUDGE: A variety of ways. By, as I said, samples, as far as samples will go. By appealing to the drug companies to supply a large number of samples, if that looks as if it might solve a temporary problem. As I mentioned before if I had someone with a chronic illness I try to buy drugs for them at cost and supply them or arrange with a druggist to do the same, and the druggist will. The druggist will arrange to buy the tablets in large quantity and supply them at a price which he would have to pay for a large quantity.

Occasionally, some of the welfare agencies can supply drugs and I have run into a little problem at one time or another having relief patients requiring drugs and no one being quite sure of who was legally responsible for paying for the prescription. They will give them a voucher for food, a voucher for fuel and maybe even a voucher for hair rinse but everyone seems to be very vague about where a voucher for drugs is to come from. I haven't met it recently.

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MR. TROTTER: I think you said you



practised in Saskatchewan?

DR. JUDGE: Yes.

MR. TROTTER: Is it easier for the average person to get drugs in Saskatchewan than it is here?

DR. JUDGE: I don't know whether it is easier or not. I do remember one thing that a medical welfare patient, that is a group of elderly patients under mother's allowance and blind patient, and that order of individual carry a card which entitles him to home and office medical care. That is, people in Saskatchewan were covered for home and office medical care; were covered for hospital care and also they had their drugs paid for at some rate or other. I couldn't tell you the details but I do know the drugs were supplied.

MR. TROTTER: Whereabouts in Saskatchewan did you practise?

DR. JUDGE: Place called Doddsland, west central Saskatchewan.

MR. RICE: Doctor, I will ask you the same question I asked the others. Have you any recommendations that you could make to the Committee as to how the cost of drugs could be reduced?

DR. JUDGE: I can't make any very far reaching suggestion as far as the cost of drugs because that is well removed from the actual practise of medicine. I am not acquainted really with the manufacturing cost and research cost of drug companies.

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Patients do pay some things which I think are rather in the way of -- I believe that it has nothing to do with the problem. I do think it has to do with the Federal Government, Federal Sales Tax on drugs as far as the patient is concerned. It isn't to a hospital but there is to a private patient having a prescription filled. 11% I believe. That is only a minor thing and perhaps it's a little cost. Dr. Halliday, I think, was circulating the suggestion that we are diluting the professional capabilities of a pharmacist by having him selling tooth paste and candies and goodness knows what else in the front of a drug store, and as a consequence I think perhaps we have far more drug stores than we really need. What we want is pharmacies, dispensaries, not department stores.

MR. TROTTER: Do you think an insurance scheme for drugs would help your patients?

MR. JUDGE: Yes, I will say that. I should qualify it in some respects because it depends on how the insurance scheme is run. I have witnessed some county medical co-operatives covering drugs under major medical benefits and I think some -- I suspect sometimes they are doing it without much actuarial knowledge of what is involved in drug cost. They got themselves into a bit of difficulty. I do feel that there should be something available for the individual who wants to protect himself or otherwise average out his expected medical and



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drug cost.

MR. RICE: Mr. Chairman, have you any questions?

MR. PRICE: I have one or two. Doctor does any of the pharmaceutical literature you receive document the result of the drug used under control?

DR. JUDGE: Wait until I get all the words lined up -- do you mean does the literature list where this drug was tested, what hospital and what authors, and so on? Yes.

MR. PRICE: And what effect they have?

DR. JUDGE: Yes, that is common constituents in these articles.

MR. PRICE: In that case do you think you can dismiss the value of this literature as useless?

DR. JUDGE: Yes. I don't know who those people are and an example has come to my attention just recently of a small drug company that hires a so-called medical director that I am acquainted with, and I have also run across medical journals that has got an article on the use of combination drugs, the article is written by this man but there is no comment about him being the medical director of that company but he writes an article on this drug; thanks the company for supplying the drug for the clinical trial and generally praises the drug. Now is that an unbiased report on a drug? And yet that will be one of the references



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no doubt in their literature.

MR. PRICE: Is the literature all of that type?

DR. JUDGE: A great deal, I think. After all, even if the research work was unbiased, and much of it is, they are only going to pick out pieces of research that were favourable to them. They are not going to mention any research articles that were unfavourable and I don't have a library big enough for all of the possible references to a given drug so as a consequence I have to, for self-protection throw away the literature and then go to the medical conventions, go to the medical journals, the standard medical journals, not throw away journals supplied by or put together by profits of the advertising. There are a number of those that we have with a subscription price on the front of them \$10.00 a year. I have never paid a subscription fee for one of them. A number of those arrive in my office. Those things are suspect. I don't know who pays for them really but I suspect who pays for them and I am not inclined to pay much attention to that kind of article.

MR. PRICE: Are you satisfied that the drugs are sufficiently well tested under proper control before they are made available to the general public?

DR. JUDGE: Yes, I think so. I am not unhappy about that at all. I have the peculiar



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experience of at the moment using a drug which is not free to the general medical practitioner because I had a patient sent to the States and he was put on a drug -- this was for leukemia -- he was put on a drug for leukemia and sent back to Canada and just as he arrived back this drug came on the market with the literature and with the notation that it would only be available for cancer research centres and since this man had been on the drug, our druggist explained the circumstances and was able to get permission to have this drug for special use, but there is this drug which even now is being worked on for many years and isn't freely available yet.

MR. BOYER: Is it very expensive at the present time?

DR. JUDGE: I can't tell you exactly. Fairly I think. It doesn't require many doses of it though. It's a pretty potent thing one way or the other. Doses only once every five days or once every week.

MR. PRICE: Where do you get the approval to use the drug? You mentioned you got it from somebody or some place.

DR. JUDGE: Well I have now -- I am not quite positive but I think that the Department of National Health and Welfare had approved the drug for research purposes and I think that we have received a concession on that drug. The pharmacist did the negotiating for us. The pharmacist in the hospital



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MR. RICE: Any further questions from the members of the Committee?

THE CHAIRMAN: Thank you very much Dr. Judge. We have been very interested in hearing your opinions and we do appreciate you having taking the time and trouble to come here and give us your viewpoint.

MR. BOYER: Mr. Chairman, before you discuss the business for tomorrow may I be permitted to make a correction in the record? Page 2196, line 15 I believe. This was while Mr. Miller of the National Sanitarium Association was here. I mentioned such drugs as P.A.S. and Streptomycin, that these were very expensive drugs when first brought on the market. Following that this is how it should read: That was why it was necessary for the Province to supply them for sanitarium patients. I believe the cost of those drugs today is very much lower, and on page 2084 there is a remark attributed to me which I did not make. Thank you.

MR. PRICE: Do you want it stricken from the record?

MR. BOYER: It's somebody else's gem.

MR. TROTTER: I suspect the remark attributed to Mr. Boyer was mine. I am not certain. I think it is though.

MR. BOYER: I thought perhaps it was. I might say Mr. Chairman, the record is usually very accurate.



MR. PRICE: Any further questions from

the members of the Committee?

THE CHAIRMAN: Thank you very much

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Judge

2324

THE CHAIRMAN: These corrections can be made. Has anyone else anything to bring before the Committee before we adjourn until tomorrow? If not, I think we have the agenda so that we will adjourn until 2:30 tomorrow.

---Hearing adjourned at 5:15.



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Select Committee on Drugs

HEARINGS

HELD AT

PARLIAMENT BUILDINGS

TORONTO ONTARIO

VOLUME No.:

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SELECT COMMITTEE ON DRUGS

Proceedings of hearings
held at Parliament Buildings,
Toronto, Ontario, on Thursday,
the 15th day of June, 1961,
at 2:35 p.m.

COMMITTEE:

MR. H.L. BOWNTREE, Q.C. -- Chairman

MR. A. WREN

MR. J. A. FULLERTON

MR. J. TROTTER

MR. R.E. SUTTON

MR. R.J. BOYER

MR. N. WHITNEY

MR. H.J. PRICE

MR. K. BRYDEN

MR. J. WHITE

MR. G.F. LAVERGNE

MR. S.J. GADSBY, F.C.I.S., Secretary

MR. HAROLD A. RICE -- Committee Counsel

MR. W.J. AYERS -- Accounting
Consultant to the
Committee



---On resuming at 2.35 p.m.

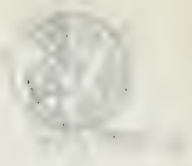
MR. RICE: Mr. Chairman, members of the Committee, we have this afternoon Dr. Wesley J. Dunn, who is registrar-secretary of the Royal College of Dental Surgeons, who is going to deliver a brief on behalf of the Association. Will Mr. Dunn come forward, please?

THE CHAIRMAN: Dr. Dunn, isn't it?

MR. RICE: Yes. Dr. Dunn, you can stand or be seated.

DR. DUNN: Thank you very much. Perhaps before I read this short presentation I may be permitted to introduce two associates who are here with me; men who are infinitely more technically competent than I certainly to answer questions in the pharmacological area. Dr. John Methven and Dr. Clifford Reynolds. Both Dr. Methven and Dr. Reynolds are members of the teaching staff of the University of Toronto. They are both dentists. Dr. Methven is an oral surgeon as well, and each has had several years experience in terms of lecturing dental students on the subject of pharmacology, and of all the dentists we have in Ontario, I know of no more competent men than both Dr. Reynolds and Dr. Methven.

I hope with your permission they may have the privilege of attempting to answer questions which you may have of what might be



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questions which you may have of what might be



considered a technical nature.

MR. RICE: For the purposes of the record, would you state your full name, please.

DR. DUNN: My name is Wesley John Dunn.

MR. RICE: And what is your position with the Royal College of Dental Surgeons of Ontario?

DR. DUNN: I am registrar-secretary-treasurer of the Royal College of Dental Surgeons.

MR. RICE: Are you a practising dental surgeon yourself?

DR. DUNN: I am a dentist, but I am not practising. My full time efforts are in this administrative field.

MR. RICE: From what university and when did you graduate?

DR. DUNN: I graduated in 1947 from the University of Toronto.

MR. RICE: After graduation, did you do any post-graduate work?

DR. DUNN: I have not done post-graduate work, no.

MR. RICE: Did you enter into practice after you graduated?

DR. DUNN: I entered into practice and stayed in full-time practice until 1955 or 1956. I'm sorry, it was either 1955 or 1956, at which time I left practice in order to assume the administrative position within the profession.



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During my practice years I also acted as editor of the journal of the Canadian Dental Association, from June 1953 until December of 1958, at which time I had to give that up because of the time consumption.

MR. RICE: Where did you practise?

DR. DUNN: I practised in Toronto.

MR. RICE: What position were you originally appointed to when you started at the Royal College of Dental Surgeons?

DR. DUNN: For the first nine months I was associate secretary during a turnover period, and then after that nine-month period, I became registrar-secretary.

MR. RICE: Can you tell us something about the Royal College of Dental Surgeons? Who are its members?

DR. DUNN: The Royal College of Dental Surgeons of Ontario is the statutory body of the dental profession in Ontario. The Board of Directors of the Royal College have certain responsibilities inherent in the Dentistry Act of Ontario.

Each practising dentist in Ontario must be a member of the Royal College of Dental Surgeons. This is in the same fashion as a member of the medical profession who practises must be a member of the College of Physicians and Surgeons. It is our responsibility to administer the Dentistry Act in this province. We are in effect a licensing

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Act in this province. We are in effect a licensing



agency or disciplinary authority, if you like, of the dental profession.

MR. RICE: You have a disciplinary committee attached to the Association?

DR. DUNN: Yes. As a matter of fact that is a statutory thing. It is embodied right within the Act itself.

MR. RICE: What are the fees attached to this Association?

DR. DUNN: Each dentist in Ontario pays an annual licence fee of \$75.00. The registration fee, which is a little different than a licence fee, is a lifetime payment. A man coming to Ontario from outside the province pays a registration fee of \$100.00 in addition to his current annual licence fee.

MR. RICE: All right, would you please deliver your brief?

DR. DUNN: Thank you.

Mr. Chairman and members of the Select Committee on Cost of Drugs:

INTRODUCTION

It is a privilege for the Royal College of Dental Surgeons of Ontario to be afforded this opportunity of appearing before the Select Committee on Cost of Drugs to provide, hopefully, helpful information to assist the Select Committee in the discharge of its important responsibilities.

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discharge of its important responsibilities.

Since receiving a communication from



the Secretary of the Select Committee, under date of May 17th, 1961, it has become increasingly apparent to us that much of the information which might prove helpful could only be derived from a statistically acceptable sampling of the dentists in Ontario. In a letter to the Committee, dated October 11, 1960, we offered to conduct such a survey. The pertinent portion of the R.C.D.S. communication is as follows:

"This office (R. C. D. S.) would be pleased to consult with the statistician of our profession to determine from him what would be a statistically acceptable sample of our approximately 2,500 dentists. We should then be pleased, at our own expense, to mimeograph and distribute a questionnaire to this sample, receive and tabulate the replies and report to your Committee at the earliest date consistent with a carefully conducted survey.

For this purpose we need only know the information you desire."

We are grateful for your Secretary's letter of May 17th, 1961 and will attempt to offer whatever commentary we are able on the basis of the somewhat limited information available. Unfortunately there has been insufficient time to permit the procedure as suggested above.



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We are grateful for your Secretary's letter of May 17th, 1961 and will attempt to offer whatever commentary we are able on the basis of the somewhat limited information available. Unfortunately there has been insufficient time to permit the procedure as suggested above.



The pharmaceutical industry and druggists, generally, have, through research and development and through the provision of facilities for dental patients to acquire appropriate pharmaceuticals on short notice, made significant contributions to the welfare of dental patients. The early employment of many of these drugs has prevented relatively innocuous conditions becoming of significantly greater consequence. The former serious sequelae of infective processes are becoming far less frequent. The simple abscess rarely now proceeds to serious complications. The formerly elaborate and time-consuming procedures for trench mouth have virtually been eliminated through modern antibiotic therapy. The ready access, through the local pharmacist, of effective analgesics to mitigate pain of dental origin, has been of great benefit to many people.

In deliberating upon the subject of cost of drugs we have attempted to consider it from two aspects:

- (A) the effect of cost of drugs upon the actual practice of dentistry
- (B) the cost to the public of drugs prescribed by dentists.

A. THE EFFECT OF DRUG COSTS ON THE PRACTICE OF DENTISTRY

It can be stated, with considerable assurance, that drug costs including anaesthetics constitute less than five percent of office overhead in the average general practice of dentistry.



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For the dentists specializing in oral surgery this cost might approximate 15 percent. There are, however, only thirty active oral surgeons in the province.

The Canadian Dental Market

The only Canadian survey, of which we are aware, having a bearing upon these concerns, is one entitled "The Canadian Dental Market" conducted by the publishers of Oral Health, a privately-owned dental journal which is circulated to Canadian dentists, each month. The survey was conducted in June, 1959 and the results reflect figures for May, 1959. A copy of this report is attached. Which is this little booklet.

Number of Dentists in Ontario

It is possible to make certain deductions by applying the information in the survey to the number of dentists in Ontario. There are approximately 2,500 dentists on the active register of the Royal College. Of this group, however, some follow non-clinical pursuits, some are retired, some are in part-time practice, and some practice certain aspects of dentistry such as orthodontics, in which drugs are very rarely employed. It is reasonable to assume that approximately 2,300 dentists could be considered to be rendering treatment services to patients.

Cost of Local Anaesthetics

The survey reveals that younger dentists tend to employ local anaesthesia more



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frequently than older dentists. Thus the average utilization of 48.1 carpules of anaesthetic per week in 1959 could probably be considered to have risen to 50 carpules per week in 1961. Thus the annual employment of local anaesthetics based on a 48 week year might be $2,300 \times 50 \times 48 = 5,520,000$ carpules. At an average cost of \$12.00 per hundred the aggregate cost for local anaesthetics would approximate \$662,400.00 or about \$300.00 per practising dentist per year.

Cost of Other Drugs

It is our opinion, based admittedly on inconclusive statistical evidence, that the average dentist would spend approximately \$10.00 per month on other pharmaceuticals employed in his practice such as alcohol, iodine, metaphen, disinfectants, zinc oxide, oil of clove, phenol, silver nitrate, hydrogen peroxide etc. Thus his yearly purchase of these items would approximate \$110.00. Anaesthetic and other drug purchases could, then, entail an average annual expenditure of approximately \$410.00.

Relationship of Cost of Drugs to Office Overhead

The Survey of Dental Practice, 1958, conducted by the Canadian Dental Association -- which again there is a copy attached right within these covers -- revealed that the mean expenses of the average Ontario dental practice amounted to \$8,660.00 which is \$155.00 above the national average.



frequently than older dentists. Thus the average utilization of 48.1 cartriges of anaesthetics per week in 1959 could probably be considered to have risen to 50 cartriges per week in 1961. Thus the annual employment of local anaesthetics based on a 48 week year might be $5,300 \times 50 \times 48 = 12,720,000$ cartriges. At an average cost of \$15.00 per cartridge the aggregate cost for local anaesthetics would approximate \$662,400.00 or about \$300.00 per practicing dentist per year.

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Thus anaesthetic and drug supplies, approximating \$410.00, account for approximately 4.7 percent of the overhead in the average dental practice.

It is significant, as well, that the cost of all dental supplies, including anaesthetics and drugs, accounts for only 18.1 percent of office expenses.

Inventory

We were asked to comment on the average value of the inventory of anaesthetics and other drugs. It is our opinion that the average dentist will retain approximately one month's supply of local anaesthetic at a value of \$24.00 to \$30.00. Other drugs could have an approximate inventory value of \$25.00 to \$30.00.

Source of Supply

The source of supply was another question asked. While it is, perhaps, possible we are not aware of any purchases made by the average dental practitioner direct from the manufacturer. Purchases are virtually entirely made from the dental supply house and the retail pharmacist. There is no discount on purchases made from the dental house but a professional discount of up to 10% on some items and, perhaps, up to 25% on pharmaceuticals for office use for which prescriptions have been written are received through the local pharmacist.

Changes in Cost of Drugs



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We were requested to express our opinions relative to the fluctuation in costs of drugs used in dentistry over the past two years. While, generally speaking, it would appear there has been an increase in the cost of drugs, and a slight increase in the dispensing fee some drugs, such as some antibiotics, have quite significantly lowered in cost.



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/dpw

Detailmen, Samples, and Promotional Literature

Detailmen, samples, and promotional literature are employed reasonably extensively in respect of dental practice. Some detailmen visit about once each year, some twice each year, and some about once every three months. In the main, these detailmen are very well informed and they provide information of a specific nature which generally cannot be included in promotional literature.

Samples permit dentists to try the product and many of these samples are given gratuitously to patients who might otherwise be required to purchase them although the samples are generally insufficient to subsidize prescriptions with the exception of analgesics which are received in rather significant quantities without cost to the profession. Commercial type mouth washes and to a lesser extent, antibiotics, are promoted through samples.

B. ESTIMATED DRUG COSTS TO THE PUBLIC

Referring again to the survey, "The Canadian Dental Market" we find that 88% of dentists state they occasionally or frequently write prescriptions. An average of 3.8 prescriptions were reported as written per week, with antibiotics, sedatives, and analgesics the most frequently named drugs.

57.4% of all dentists had prescribed antibiotics during the week which was surveyed.

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prescribed analgesics.

It is very difficult to attempt to determine costs to the public on these items because of the many varying factors which could apply. However we have attempted, again on the basis of the information in "The Canadian Dental Market", to determine costs on the three major pharmaceuticals -- antibiotics, sedatives and analgesics.

1. 60% of 2,300 dentists will each prescribe approximately \$200.00 per year in antibiotics. Annual aggregate cost is approximately \$276,000.00.
2. 50% of 2,300 dentists will each prescribe approximately \$50.00 per year in sedatives. Annual aggregate cost is approximately \$57,500.00.
3. 50% of 2,300 dentists will each prescribe approximately \$50.00 per year in analgesics. Annual aggregate cost is approximately \$57,500.00.

NOTE: The above amounts include the dispensing fee and especially in respect of #2 and #3, this fee is a significant portion of the amount indicated. Also #3 may be questioned somewhat because of the rather significant amounts of analgesics supplied gratuitously to the profession. Many of these samples of analgesics find their way into the hands of dental patients directly from the dentists.



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cost is approximately \$27,500.00.

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CONCLUSION

The above commentary represents a sincere attempt to apply rather limited statistical information in juxtaposition to a reasonable knowledge of the general conduct of dental practice in Ontario in order to assist the Select Committee on Costs of Drugs in the fulfilment of its terms of reference. The offer contained in our letter of October 11th, 1960 is reiterated. We continue to be prepared to conduct a survey among the members of the dental profession in Ontario should, in the judgment of the Committee, such a survey be desirable.

In the meantime should the Committee indicate there are other areas in which we might be considered competent to comment we should consider it only a privilege to be afforded the opportunity.

MR. RICE: Dr. Dunn, on page 3 you estimate the annual average cost of drugs prescribed by dentists at \$410, and on page 2 you estimate that approximately 2,300 dentists would be giving treatment to patients. Would it be fair to multiply the 2,300 by the \$410 as the total drug bill for Ontario?

DR. DUNN: I would think that would be a fair statement. We have tried - if we have estimated at all, we have tried to think of it on the high side, perhaps. Those that we have done spot checks on are inclined to think that they pay a little less than the amounts here, but we have



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tried to err, if this is the way we should be erring, on the high side, and I would think that would be a reasonable figure.

MR. RICE: How many different types of drugs would dentists prescribe or use?

DR. DUNN: The prescriptions you will find in the Canadian Market, those which were given - you will find it on page 8, I think, the major areas of prescription writing. As I say, at this particular juncture I think Dr. Reynolds and Dr. Methven would be more competent to answer. Analgesics, vitamins, tranquillizers, these seem to be the major areas.

MR. RICE: Perhaps you could tell me how many different manufacturers supply those types of drugs?

DR. DUNN: That is a question I am incapable of answering. I don't know whether my two friends are capable of answering that or not.

MR. RICE: Is there competition among the manufacturers in supplying these types of drugs? Is there more than one manufacturer supplying the same type of drug?

DR. DUNN: Oh, I think there is no question of that. I think there is more than one manufacturer, specially in the first three categories where the bulk of dental prescriptions take place.

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MR. RICE: Would the dentists have



any preference for certain manufacturers over other manufacturers?

DR. DUNN: I would think the answer to that question would be yes, most certainly. But I was a practising dentist, and I had preference for certain manufacturers, perhaps more on the intangible aspect than on the quality of the product, such as the services the detailman might be providing. I would be very doubtful, though, because of our confidence in the quality of pharmaceuticals, that there would be too much selectivity in the thinking that one product is better than another.

MR. RICE: Would you have a range of selectivity on the price?

DR. DUNN: I think again I don't think I am competent to answer that question. I think here either Dr. Reynolds or Dr. Methven probably could.

MR. RICE: When the dentists order these drugs, do you know if they order them under generic or brand names?

DR. DUNN: Here again I find it very difficult to answer that question, because I believe that both are done. I think some dentists will certainly specify a particular product, whereas others - and I am inclined to think that the younger dentists will be more inclined to prescribe on the basis of the generic names, simply because in the last ten years, perhaps, and I think largely due to



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the fact that we now have dentists in the teaching programme in the Department of Pharmacology, I think there is more stress placed on this subject than there was perhaps ten or more years ago, and I think the younger dentists today would be more inclined to prescribe on this basis rather than on the former methods which were employed.

MR. RICE: Does the Royal College of Dental Surgeons provide its members with a tariff?

DR. DUNN: You are speaking now of dental fees?

MR. RICE: Yes.

DR. DUNN: No, the Royal College of Dental Surgeons does not, but the Ontario Dental Association does. Perhaps I should explain that the Ontario Dental Association is a voluntary body of Ontario dentists which has certain functions apart from those provided by the Royal College of Dental Surgeons. The annual convention, for instance, a responsibility of the Ontario Dental Association, has a dental health committee, it publishes a journal, it has a committee on public relations, and it was this committee which developed a few years ago a fee schedule, which, of course, is neither a minimum nor a maximum schedule but is designed for average fees for average circumstances.

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PB/dpw

In other words it doesn't take care of something completely out of the ordinary either one way or the other. This fee schedule which is worded in its preamble in very much the same fashion as the fee schedule of the Ontario Medical Association, "Average charges to persons of average means for services requiring average skill and responsibility".

MR. RICE: Are x-rays and drugs, sir, disbursements or something to be reflected on the account?

DR. DUNN: I am not sure I fully understand the question but there is generally speaking a specific fee for a radiographic or x-ray service. I am not sure that I understand your question by saying "extra".

MR. RICE: In other words is the account made up showing a fee and showing an x-ray charge and a drug charge and so on?

DR. DUNN: I could certainly say as far as the latter is concerned because the cost the latter sir, because it is inconsequential, the drug charges to the actual dental services, that would never be a specific account. It is conceivable an itemized statement might be given for radiographic services just as an itemized statement might be given for silver coating or gold inlaying, whatever service is given. I would think again, however, that the majority of dentists do not specifically account on the bill. They are, perhaps, more likely



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to discuss the treatment procedure with the patient prior to initiation of the service. Here again with a group of 2,300 individuals it is very difficult to be able to generalize on so many of these things.

I think I can speak emphatically the drug charges employed as an adjunct to the treatment procedure and would never be itemized on a dental account they are so infinitesimal.

Carpules of anesthetic would be the most significant expense and would be anywhere from 10 to 14 cents depending on the type of local anesthetic that was employed.

MR. RICE: Are there any Ontario dentists that dispense drugs; that is, apart from the drugs that they use in the treatment in their office?

DR. DUNN: I know of none except in this one case that a tooth has been filled and the man has received a quantity of analgesics, rather than writing a prescription a person might say here are a dozen capsules and write - they take one every so many hours and simply give them to the patient. In the sense I think you mean the word dispense drugs, I would say the answer is an unqualified no.

MR. RICE: I was wondering if they dispense drugs and charged a dispensing fee. You show a dispensing fee.

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MR. RICE: When dentists write prescriptions do they generally write these prescriptions in their trade names or generic names?

DR. DUNN: That is the one I tried to answer a few moments ago and it is very difficult. I don't know that I can generalize on it. I think I said the younger dentist is probably more inclined to write on the basis of the generic names simply because of the emphasis, the increasing or greater emphasis on pharmaceuticals as an undergraduate study. I think I said it is largely because of Dr. Methven and Dr. Reynolds, who are dentists lecturing on dentistry to students on this subject. Prior to these gentlemen becoming involved no dentist was lecturing the dental students on the subject, and therefore I think it was more difficult for a lecturer from the Department to bring this into the dentists' own specific area of responsibility.

MR. RICE: The question I asked you before was when the dentists purchase drugs, do they purchase under the generic rather than drug



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names, have they got a preference when they are buying the drugs themselves?

DR. DUNN: Here again I don't believe I can really answer that question. I would be inclined to think if he is at all conscious of the subject that he would tend to purchase them under generic names, but I really don't feel competent to answer the question. Maybe or perhaps Dr. Methven or Dr. Reynolds would have the information on it.

MR. RICE: Has there been any complaint to your College with regard to drugs, as to their quality or cost or otherwise?

DR. DUNN: You are speaking now of complaints from members of our profession?

MR. RICE: Yes, complaints from members of the profession or complaints from the public.

DR. DUNN: No, we have had no complaints whatsoever respecting quality or price, but here again I think, and I don't want to be repetitive, but the cost of drugs within the active practice of dentistry is not that significant. It is such a small percentage of the actual overhead expense by the actual dentist. Perhaps after the efforts of this Committee they may look at it a bit more, but they haven't done up to this time.

MR. RICE: Mr. Chairman, have you any questions for Dr. Dunn?



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questions for Dr. Dunn?



THE CHAIRMAN: Are the number of dental students increasing or decreasing each year?

DR. DUNN: Well, the number of dental students is increasing for one very pertinent reason; that is, because of the new dental school being opened in December of 1959. Interestingly enough and we have been concerned with this problem, we found that the number of applicants had been, for the last years, less than we should like to have. This trend has seemed to reverse last year. I looked at the figures the other day. Unfortunately I can't quote them with accuracy at this time, but I looked at the figures the other day and found we had approximately 100 more applicants to the Faculty of Dentistry last year than the year before. I mean, after coming fresh on the Admissions Committee yesterday afternoon, we found the number is certainly holding its own and perhaps increasing a little from last year. I think again this was largely due to the rather strenuous efforts on our part in the area of equipment, and work we have done by participating in the Mediscope and by lectures to graduate classes and career days and what-not within the high schools and by bringing 50 or more students from Eastern Ontario and entertaining them here in Toronto along with dentists at the University, and the dental school and I think we have created a greater interest in the field. This, I believe, has been reflected in the increasing number of applicants.



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There is another thing on that as well, that they also have the auxiliary group known as Dental Hygienists, and we have the capacity of 50 per class, and up until this year we have been far from being able to bring this group up to its capacity.

But the Dean told me about a month ago that we were then farther ahead than we were last year in mid July, so I would think that we are going to have an increased number of people in the dental hygiene class as well.

MR. WREN: According to your statistics or information on page 2, it would indicate that there is one dentist for approximately 2,000 population, is that a fair average?

DR. DUNN: Actually, I think it works out to be something around one to 2,345 or something of this nature. The figure that I am giving here was given in terms of attempting to determine the number of dentists who might be available, if you like, to write prescriptions or employ drugs in their practice.

Our orthodontic friends, as you know they are the men responsible for the re-alignment of teeth, the creating of normal occlusions, I would doubt that they would use drugs at all. They are just not involved in the tissue cutting field, so that our actual number of dentists as of today, as a matter of fact, is something around 2,509.



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Of course this increase of new graduates who have just become registered would average it somewhere between one to 2,300 and 2,400, which is better than the national average which is slightly over one to 3,000.

THE CHAIRMAN: Is that number going up or down?

DR. DUNN: The number is going up. By that I presume by "up" you mean is it getting worse from the public standpoint?

THE CHAIRMAN: Yes.

DR. DUNN: Very definitely it is. It is not going up too rapidly in Ontario, but there is no question that the number of people is increasing more quickly than the number of dentists. We hope with the increased number from the new dental school it will tend to offset that, but even with maximum enrollments, and based on the Gordon Commission estimates, we still think by 1980, unless further dental facilities are provided, we are going to find ourselves with a worse ratio than we have at the present time.

MR. WREN: Is there only one school in Ontario?

DR. DUNN: Yes, just one in Ontario. We have six in Canada altogether.

MR. BRYDEN: What would you consider an acceptable ratio?

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and the demand for service, which we know very little about.

MR. WREN: Do you get many requests from communities for graduates?

DR. DUNN: Yes, we get quite a few. The Ontario Dental Association through its dental public health committee is giving consideration to this matter of the placement of younger dentists in communities which really need them. We never like to see a young chap graduate from the University of Toronto and set up -- and I am speaking figuratively now -- at Yonge and Bloor and not be particularly busy, whereas if he were fifteen miles from Toronto, he would probably have more to do within two weeks than he could cope with. But as long as we live in a free society, I am afraid that type of thing will exist.

MR. WREN: This is a matter of comment, but in my area there is room for several who could make a pretty handsome income.

MR. WHITE: Do you think it is the lack of facilities that is resulting in the lower proportion of dentists per population, or do you think that the younger people may think fluoridation will make dentists obsolete?

DR. DUNN: It would be rather nice if that is what happened. As I said to someone today -- I have been speaking to a service club at noon today, and someone was making a comment about the

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MR. BRYDEN: In view of the sparsity of population in the other areas, it would probably be desirable to have a lower average than a higher ratio, at any rate more dentists in relation to the other people in the more sparsely populated areas.

DR. DUNN: You have a problem in those areas. The community has to be of a sufficient size to support a dentist. Either that or you have to have communities within close proximity to each other, between which he might divide his time. I think any community which has perhaps fewer than 1,200 to 1,500 people is going to have a difficult time supporting a dentist, because while we realize that almost everybody needs some dental service, it does not necessarily follow that everybody demands it or asks for it or wants it. Therefore we know that from this 1,500, we have to expect that a certain percentage of them are either not dentally oriented or they are not particularly concerned, and where we have a smaller number actually making the demand for the service, this has always been a perplexing problem in dentistry, to see if we can determine the relationship between the need for dental service, which we know something about,



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What they didn't say, however, was in 1945 there was one more dentist in Brantford than there is today with a population almost double.

Fluoridation is still not an absolute preventative. It will not do too much against the child who insists on stuffing himself with fermentable carbohydrates of one kind and another, and it will certainly do nothing in helping those who have acquired traumatic injuries, the unwisdom of the child from selecting a father with large teeth and a mother with small jaws, so that we have a very bad arrangement.

Fluoridation will do nothing for them, but we do know that it will reduce the incidence of tooth decay by approximately two-thirds. We are talking about bargains, so I will suggest to you with great respect that this is perhaps about the best bargain that we have.

MR. WHITE: I read in the paper some years ago in an American publication that if the United States government were to spend, I think they suggested one billion dollars over a ten or twenty year period, that tooth decay likely if that amount is spent on research, would be ended forever.

DR. DUNN: I think that is a Utopian point of view, and I think it is a very desirable



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one. I can assure you of this, that the dental profession is working rather assiduously towards that goal through basic research, in the hope of doing that. It might sound trite, but the business of the medical and dental profession is to put themselves out of business.

MR. WHITE: I thought there was almost no money being spent on dental research, very little anyway.

DR. DUNN: Certainly in proportion to the amount spent on treatment, that is absolutely true. But we do have, I think, one of the world's largest research divisions right here in our own school in Toronto, and quite frankly some of us are very proud of the work that is going on.

Certainly there is a National Institute of Dental Research recently created at Bethesda Maryland, at \$3,000,000.00 by the United States Government, and I am quite sure that this is a fact, that every year we find greater amounts of money being spent in the field of research. We find more and more dentists coming in and taking post-graduate training either in histology or bio-chemistry, or some of the basic sciences, and we have already had some rather interesting developments in this field. To be fair, I don't think sufficient money is being spent, but at the same time we as yet don't have sufficient personnel available to spend the money, even if we had it.



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MR. WHITE: How much are we spending here in Ontario?

DR. DUNN: It seems to me that here again I cannot, I don't think, give you these figures, because this has now been incorporated, as I understand it, within the entire University of Toronto budget, but I think somewhere in the neighbourhood of \$150,000.00 to \$200,000.00, perhaps even up to a quarter of a million dollars is being spent in this field in its broadest sense.

The profession itself is, doing very little in the way of research on products, the tangible things, which people recognize. They are much more interested in basic research, to find out why teeth decay or what they can do to prevent this decaying process, but we have found out even in our own faculty here, some rather interesting things such as, for instance, the fact that even the shape and size of teeth have a bearing on their susceptibility to tooth decay.

Doctors Paynter and Grainger who appeared before another committee dealing with the fluoridation question, are two men that have actually done some work in determining this to be a fact. I think a fair amount is being done in dental research, but we certainly have to do a lot more.



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/dpw

MR. FULLERTON: Mr. Chairman, it seems of consequence that the report of the Hospital Committee on the cost of drugs and the Dental Committee run approximately the same, roughly 4% of their total overhead. I wouldn't like to suggest collusion in preparing these reports, but I would like to ask Dr. Dunn if he prepared this report himself.

DR. DUNN: This report has been prepared by three people; by Dr. Methven, by Dr. Reynolds, and by myself, and frankly, my only relationship or knowledge of the hospital report was what I read in the paper.

This again as I have said, or have tried to say here, this has been done on information which personally I did not find statistically acceptable, but it is a sincere and genuine attempt to apply the information we do have to your terms of reference. I can assure you that even the Board of Directors of the Royal College of Dental Surgeons which appointed the three of us to prepare this, did not see this report until yesterday when they opened their mail. This has been done by us.

MR. FULLERTON: Can you tell me what prompted the survey in 1958? Do you have them every so many years, and you quote figures for 1958 at page 3.

DR. DUNN: You are speaking of this document that I have attached? You mean the survey

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of dental practice by the Canadian Dental Association?

MR. FULLERTON: No, on page 3 of your report. Dental survey of 1958.

DR. DUNN: Oh, yes. That is the one, as I say, which is attached here. I have included the entire report for your perusal if you wish.

It is an economic survey performed by the Canadian Dental Association to attempt to determine any or all economic factors having a bearing upon the practice of dentistry. So often we are told or we are asked how much does it cost to provide dental service to people; how much does it cost to operate practices; what is the income of a dentist; does that income change as his type of practice changes; the number of auxiliary personnel changes, and this again is simply a fact-finding survey, which, incidentally was the second one.

There was one done in 1953, and this one of course was done in 1958.

It is rather interesting that the net income of dentists as determined from this survey vary by an amount of something like only \$50 from the figures from the Dominion Bureau of Statistics relative to income tax figures. This is just an effort by the Association to attempt to have as much knowledge as possible of all economic factors of the provision of dental care.

MR. WREN: Do you have many women graduating?

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MR. WHEAT: Do you have many women

translating?



DR. DUNN: We have a few more women than we had heretofore. Dentistry has been for some reason or other not an appealing profession to women generally on this continent, yet we know of certain Scandinavian countries where the majority of dentists is women. We have I think about 80-some women dentists in Canada. We have between 50 and 60 women dentists in Ontario.

MR. WREN: I was just wondering in the light of what you say that you are not getting as many enrolments as you would like, if it might be made known to women that it is a profession they could successfully practise in?

DR. DUNN: Well, again, we try to make the effort, but as a prominent obstetrician said here, women do have certain biological commitments, and this makes it perhaps somewhat difficult to manage entering into a profession which takes five years at a fair cost, especially if they wish to combine this with marriage and raising a family.

On this continent anyway, this has just not been particularly appealing. If anybody here has any suggestion as to how we may persuade women to do these things, we would be delighted to hear it because we think they have a place.

MR. WREN: They go in medicine and the other professions?

MR. TROTTER: When a dentist prescribes a drug for a patient, is the drug apt to

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DR. DUNN: I am trying to determine this question. I believe you are saying is he likely to prescribe a drug which is, how will I say this, which is so selective in its action or something, or such a powerful drug that its cost is quite high. I think you will find in the main drugs prescribed by the dentists are those which most people would consider the less expensive variety: analgesic and antibiotic of the more standard type. I think it would be rare that you would be getting involved with one of those highly selective pharmaceuticals.

MR. TROTTER: Do the dentists have any arrangements among themselves to help those people who possibly could not afford to pay for a drug?

DR. DUNN: We have no arrangement within the dental profession to provide drug costs other than what has been stated here. If a dentist happened to have samples, I think you will find many patients will be given these. They will be given naturally without cost. But if for instance someone is given a prescription, something that is very necessary, there is certainly no official arrangement whereby that cost might be assumed by some agency within the dental profession.

If it is a welfare situation, then



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one will certainly provide the appropriate document to the appropriate sources as far as confirming that this should be purchased, but we have no arrangement within the profession.

MR. TROTTER: When you were practising, did you find that a large number of the samples that were sent to you were thrown out?

DR. DUNN: I don't think really they were thrown out. Certainly some were. I don't think there is any question about that, simply because the sample may be of a product, let us say it has something to do with periodontal disease, disease of supporting tissue of teeth, and if the dentist is in the habit of referring such treatment to a periodontist, or at least general practitioners who are more competent in that field, and something were provided specifically for a periodontal disease, it is quite likely it would be thrown out.

Again, to attempt to generalise as to what proportion of drugs received gratuitously would be disposed of, I don't think I could give you an answer to it. Certainly some are.

MR. TROTTER: If you received a sample and used that sample, would it help to sell you the drug?

DR. DUNN: If it did what I wanted it to do, I certainly think it would. For instance, if we had a problem of trench mouth, and some anti-biotic lozenge were supplied, and we employed that



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MR. TROTTER: If you were trying to decide what drug is to be used, what means would you use in order to inform yourself, and I might add as part of that question, what would be the most persuasive means of persuading you to buy?

DR. DUNN: I would feel that I would want to know any promotional literature or informative literature employed respecting the drug. I think I would like to be sure that the research work done upon it or the clinical trials done were consistent with sound scientific procedures.

How to explain how I would go about attempting to determine if this is so, I don't know, but one I think, trained in scientific discipline, does become conscious of the methods of attempting to assess reports which appear in the literature or which appear through the ads on the part of the pharmaceutical manufacturer.

Here again I suppose most dentists would look upon certain companies as being thoroughly reliable and honourable, and perhaps a dentist will say if company A has put out this product, they have



and found a rather dramatic reduction in the severity of the infected process going on, I think one would say that has worked very well, and would probably want to use it again, but to attempt to determine the persuasion these samples may have in terms of reordering the product or using it in the future again, I find it very difficult to attempt to answer.

MR. THOTTER: If you were trying to decide what drug is to be used, what means would you use in order to inform yourself, and I might add as part of that question, what would be the most persuasive means of persuading you to buy?

DR. DUNN: I would feel that I would want to know any promotional literature or informative literature employed respecting the drug. I think I would like to be sure that the research work done upon it or the clinical trials done were consistent with sound scientific procedures.

Now to explain how I would go about attempting to determine if this is so, I don't know, but one I think trained in scientific discipline, does become conscious of the methods of attempting to answer reports which appear in the literature or which appear through the ads on the part of the pharmaceutical manufacturer.

Here again I suppose most dentists would look upon certain companies as being thoroughly reliable and honorable, and perhaps a dentist will say if company A has put out this product, they have



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probably done so on the basis of good sound scientific information. I suppose it is the same as with anything in which one engages. If you have confidence in the person who is producing the product, and that confidence has never been violated, I think the tendency will be of course to be rather persuaded by the views of that particular company in respect to its products.

MR. BRYDEN: One of the criticisms of drug promotional material that I have read written by medical men is to the effect that frequently in advertisements there will be references to scientific magazines; frequently a large volume of references. The references do not necessarily bear out the claims made in the advertisements, but there is an attempt to create an impression that these very reputable journals support what is said in the advertisements.

Do you find that with regard to products promoted to the dental profession?

DR. DUNN: Well, I think this is indigenous to almost any field. I have seen promotional literature which was not worth the ink used to print it. One, however, if he is at all acute, I think when he sees such a thing come from such a firm, and determines that this is pretty fallacious material or unfounded material, is going to be a very difficult man to attempt to persuade that some other product of that firm is a good one.



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MR. BRYDEN: How would he find out if he doesn't check the references which he probably hasn't got the time to do?

DR. DUNN: This is probably partly true, but it is his responsibility to assure himself beyond any reasonable doubt that the product which he is employing on some treatment procedure will do what he wants it to do.

I will admit with the tremendous amount - almost a flood - of scientific literature coming out, it is very difficult for the practising dentist to do so, but there are publications available, publications which emanate from responsible scientific sources which are pretty well able to do this. Every month the journal of the Ontario Medical Association - I believe they call it the Ontario Medical Review - has a whole section prepared by Dean Hughes, Dean of the College of Pharmacy, and when one reads this, and I don't pretend to be competent in the medical field at all, but when one reads this, I think he can say "This is well reported; I think I am safe in dealing with this".

The area which caused us and still causes us in dentistry the greatest distress is the exorbitant claims which have been made for many dentifrices, and in this regard we have become somewhat jaundiced because of these exorbitant claims which don't bear the light of scientific scrutiny, and that is why it is difficult for any



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dentifrice manufacturer today to be overwhelmingly persuasive with the dental profession because we have experienced so much very dreadful literature on it.

MR. BRYDEN: Does toothpaste do any harm - it might not do any good, but does it do any harm?

DR. DUNN: Again, I do not think it does any harm providing the utilization of the tooth brushing technique with it itself is not harmful. I don't think there is any toothpaste that abrasive that if people used good tooth brushing technique, would be harmful, but the way many people brush their teeth is harmful because it tends over a period of time to wear the enamel where enamel is often very thin, and certainly rather than stimulating oral or gingival tissues, it tends perhaps to irritate them more than anything.

I don't know of any dentifrice which is actually harmful. We are a little concerned or were at one time with some of the liquid dentifrices which were rather acidic in nature, but unless I am out of the field entirely, I find these are used very, very infrequently.

MR. WREN: You don't go for that "Look Ma, no cavities" deal?

DR. DUNN: No, not in that regard. As I say maybe we tend to be ultra-conservative here, but much of the dentifrice advertising I



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think is very unfortunate. Some of it is good. I think some of the firms do attempt to give a reasonable position of the product.

MR. PRICE: That is subject to certain control? They can't go beyond a certain point? If it is on television they have to be reasonably accurate?

MR. WREN: Certainly in one case a definite impression is left **that** just because you use that toothpaste and for no other reason, there are no cavities.

MR. BRYDEN: There is no control on the advertising of dentifrices. One I have seen that strikes me as pretty outrageous - I don't know that there was any control on it.



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Methven

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MR. RICE: Dr. Dunn, perhaps you could solicit the services of Dr. Reynolds and Dr. Methven and see if you could give the Committee some estimate as to the number of different drugs that a dentist would use and prescribe, and, secondly, whether there is a large range or difference in the prices in the manufacture of those drugs.

DR. DUNN: If I might call upon Dr. Methven. I feel I am not competent to answer this question.

MR. RICE: What is your name, sir?

DR. METHVEN: John Methven.

MR. RICE: You are Dr. Methven?

DR. METHVEN: That is right.

MR. RICE: You are a dental practitioner?

DR. METHVEN: Yes.

MR. RICE: And I understand you are attached to the School?

DR. METHVEN: That is correct.

MR. RICE: What do you teach at the School?

DR. METHVEN: Oral surgery.

MR. RICE: Can you assist us as to the number of different types of drugs a dentist would prescribe or use in his practice?

DR. METHVEN: I think if you look at the report, Dr. Dunn has itemized the general heading under which these drugs might fall. Each



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MR. RICE: What is your name, sir?

DR. METIVIER: John Metivier.

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DR. METIVIER: That is right.

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one of those general headings would have perhaps four or five manufacturers involved in making that specific product, and the actual cost of making these drugs or the cost to the dentist would vary, cost to the patient would vary. But I think without a rather clear survey of costs you would be guessing; it would be a matter of a few cents one way or another. I don't think there would be any great significance. As you know, any drug that is ordered by its generic name, there are manufacturers who have come into the market more recently who are manufacturing those drugs and selling them at a reduced price. Now, this is true of some antibiotics, penicillin, for instance; it is true of chloromycetin, which is an antibiotic but which was more expensive when it first came on the market. The manufacturers have reduced the cost of this since it has come on several times. But I believe you could still buy it as a generic drug more cheaply than you could buy its trade name. There is a significant difference in the cost of a drug in that respect. The cost, for instance, of an analgesic, a tablet which would contain aspirin, caffeine and codeine in various quantities would not vary a great deal between one manufacturer and another. It is a basic product, it is a product carried by all druggists, and it has been on the market for so many years that there is a reasonably standard price which is not terribly high.



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MR. RICE: In your experience do you find that as drugs are on the market for a period of time prices tend to stabilize, even out?

DR. METHVEN: Yes, it is true. The manufacturer who comes on the market with a drug which is specific for some particular condition has the market pretty well to himself initially and his costs undoubtedly reflect his research costs, his promotional costs. But, as you know, it is possible sometimes to, through a lease arrangement, bring the product on the market under another name or by changing the molecule slightly but not its final effect, bring the product on the market again under another name, and this does tend to reduce the cost of the drug; that is, as more manufacturers are competing the cost goes down.

MR. RICE: In your school do you instruct the students to prescribe in the generic name or brand name?

DR. METHVEN: The students are only taught in the generic name, they are not taught trade names. On coming out of school a student would, in setting up a practice, a graduate would probably consult with the pharmacist and tell him some of the drugs that he would be ordinarily prescribing. If he had any particular preference for one drug over another the pharmacist would be then inclined to carry it, the local pharmacist would carry it as a convenience. It would be quite



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difficult if every dentist had a different type of product, and that is where the use of a generic name is most effective. If a druggist doesn't have that specific product he can substitute another which might be less expensive but which would have the same ingredients because it is written out in its full form, it would have to comply with the standards for that particular product.

MR. RICE: When there is a difference in price between the generic manufacturer and the brand name manufacturer and the dentist is prescribing, which one has he the tendency to prescribe?

DR. METHVEN: I think in the interest of the patient he would prescribe the less expensive drug; he would be satisfied that if it was advertised as chloromycetin, B.P., or any drug according to the British Pharmacopoeia, it would have to meet certain standards, and the Food and Drug Department would see that it did. So he is quite satisfied in supplying the patient with the generic name of the drug in terms of quality, he has no fear in prescribing aspirin instead of Anacin, he knows he is getting the quality.

MR. WHITE: Will he necessarily have much information on price?

DR. METHVEN: I think he will find, he will glean a great deal of information from his patients. If a patient feels that the cost of a drug has been excessive he definitely will tell the dentist.



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But this is the service the detailman does supply, that when he arrives he tells you about the drug, any information that isn't in the literature he is usually equipped to either get it for you or tell you about it. He will also tell you the cost of the drug, what it will sell for, and he will also tell you if the cost has gone down. The dentist must take this into consideration in prescribing the drug, naturally; he is interested in clearing up whatever the drug is for, and I think the cost is a factor. There is a reasonably wide spread of costs between penicillin as manufactured by one pharmaceutical house and another, and there is no great evidence that one is that superior, and the less costly drug I think would be more frequently --

MR. WHITE: Even on a thing like aspirin I wouldn't even try to pronounce the generic name, but as far as the consumer is concerned there is a very wide range for that particular product.

DR. METHVEN: There is a very wide range between Milk of Magnesia, B.P.; you put it in a bottle and call it something or other, and it is more expensive. If you go in and ask for one specific drug this may cost more. If you buy Rexall's brand of that particular product, then you don't pay that much for it. You know what you pay for a bottle of aspirin.

MR. WREN: A person goes into the drug store and offhandedly buys aspirin, and there



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is a variety put out by other companies, is the sense of the tablet relatively the same?

DR. METHVEN: Yes, it is relatively the same, depending whether you buy the average adult dose or a child's smaller aspirin. They are essentially the same. The ingredients are not always the same, but if you buy specifically aspirin and order it as such, then you get just that. But you can buy Anacin with a combination of several ingredients; you could buy Frosst's 222's which would be a slightly different combination of ingredients, but if you ordered a A.P.C. & C. with codeine, there would be a selection which could be substituted for that.

MR. RICE: Any other questions, Mr. Chairman?

THE CHAIRMAN: We may say, Mr. Rice, that it would appear that the Provincial Drug Bill insofar as drugs are used by the dental profession is in the order of, say, a million dollars a year.

MR. RICE: My figure was \$943,000.00 close to a million dollar.

THE CHAIRMAN: And I think the other pertinent observation is that that dosage or use of that million dollars worth of drugs is spread out in very small quantities across all of the prescribing dentists, their office operation and against their patients but in relatively smaller quantities.

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Methven

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which we are talking, Dr. Dunn, a fair conclusion?

DR. DUNN: I think that is, Mr. Chairman.

THE CHAIRMAN: Thank you, Dr. Dunn for coming, and your assistants with you, Dr. Methven and Dr. Reynolds.

MR. RICE: Mr. Chairman, I should report to the Committee on certain developments in Ottawa, These were mentioned earlier this month.



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THE CHAIRMAN: Thank you, Dr. Dunn for

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MR. RICE: Mr. Chairman, I should report

to the Committee on certain developments in Ottawa,

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I perhaps should first read to the members of the Committee the Combines Investigation Act, 1952, Section 42(1). No doubt many of you are familiar with this. Section 42(1) reads:

"That the Director upon his own initiative may and upon direction from the Minister or at the instance of the Commission shall carry out an enquiry concerning the existence and effect of conditions or practices having relation to any commodity which may be the subject of trade and commerce and which conditions or practices are related to monopolistic situations or restraint of trade, and for the purposes of this Act any such enquiry shall be made to be an enquiry under Section 8.

Now, in April 1958 the Director Mr. W. T. McDonald, Q.C., pursuant to that provision initiated an enquiry into the manufacture, distribution and sale of drugs in Canada. This enquiry was continued and completed by the present director E.H.W. Henry earlier this year. Then nearly three years later the old material was analyzed and documented and prepared by the director and submitted to the Restrictive Trade's Commission. At that point the document and all the material was considered a private document which was referred to earlier this month.

Section 42(2) of the Combines Act provides: "It is the duty of the Commission to consider in evidence all material brought before



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us under Sub-section (1) together with such further evidence or material as the Commission considers advisable and reports thereon in writing to the Minister, and for the purpose of this Act any such report shall be deemed to be a report under Section 19.

I am informed by Mr. A.S. Whitely who is a member of the Restrictive Trade Practices Act that the documentary material was tabled yesterday and that it is now a public document. In view of this I have requested sufficient copies for the members of this Committee. I understand Mr. Whitely will be sending these to me providing the supply at Ottawa is sufficient.

Also, Mr. Chairman, the Chairman of the Restrictive Trade Practices Commission yesterday made an order, and I received a copy of that order this morning which is as follows: "In the matter of an enquiry under Section 42 of the Combines Investigation Act relating to the manufacture, distribution and sale of drugs.

"The first hearing in the above enquiry has been set by the Restrictive Trade Practices Commission to be held in a courtroom of the Exchequer Court of Canada in the City of Ottawa, Ontario, commencing at ten o'clock on the morning of Tuesday, July 4th, 1961. Further hearings are being arranged in other cities in Canada at subsequent dates in July. The Commission



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plans a final hearing in October, probably in Toronto. At these hearings argument may be presented by or on behalf of the Director of Investigation and Research, and representations by way of evidence and argument may be submitted by any interested party.

"I have received, from several parties interested in the enquiry strong objections to hearings being held in public. I have also received various submission urging that the hearings be public. All representations made to me have been carefully considered, and I have come to the conclusion that in this enquiry the public interest would be best served by public rather than by private hearings. I therefore order that all hearings before the Commission in this enquiry shall be conducted in public. Dated at Ottawa this 14th day of June, 1961. C. Rhodes Smith, Chairman, Restrictive Trade Practices Commission".

Mr. Chairman, I understand although the material prepared by the Director will be presented to the Commission they will also hear such further and other material as may come before them and I bring this report to the Committee, make this report to them, so the Committee can consider any future proceeding in the light of this Ottawa development.

MR. WREN: Would it be your opinion that freezes this Committee or puts it in sub judice -- is that the word?



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future proceeding in the light of this Ottawa

MR. WHEAT: Would it be your opinion

that freezes this Committee or puts it in and judges



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MR. RICE: No, it wouldn't in my opinion. I would submit this Committee could still continue because the fear of investigation may overlap.

MR. WREN: I didn't mean that. I mean would it freeze -- are we any longer under a liability to restrain from asking any questions?

MR. RICE: Yes, it definitely freezes you. I expect to have copies for you. I expect to have copies for you.

THE CHAIRMAN: You are talking about questions on material contained in this interim report?

MR. RICE: Yes, the director's material.

MR. BRYDEN: Mr. Chairman, could I ask if the Committee could perhaps subscribe for, shall we say, two copies of the stenographic record of this hearing and that those copies be available in the Committee's office for consultation by members of the Committee?

MR. TROTTER: Could we only have two or would it be too expensive?

MR. BRYDEN: I thought two -- I don't know how expensive this sort of thing is. My impression is it is very expensive.

MR. TROTTER: After all, the Americans will supply with all the copies we need free. We needn't buy them.

MR. WREN: He was talking of the transcript, the transcript of the hearings.



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MR. TROTTER: In Ottawa starting on July 4th.

MR. BRYDEN: I don't mean this report that has now been tabled in the House. Surely we can get enough copies of that for each member. I am thinking in terms of the hearing that will be commencing. Presumably there will be some sort of stenographic record maintained. I don't know what kind.

THE CHAIRMAN: Why don't you make the necessary enquiries and see what the situation is.

MR. BRYDEN: The U.S. Senate will give us the stuff free of charge.

MR. TROTTER: I hope the investigation in Ottawa, Mr. Chairman, won't stop our enquiry. I don't think it should.

THE CHAIRMAN: The only way I can see it would effect us would have to do with the situation we were in last fall when the general price enquiry was on when we were sitting. I would think it would be a matter of privilege on the part of any party to this hearing if the answer to the question directed to him were going to incriminate him.

Well, there being no further business...

MR. TROTTER: I was going to ask one question regarding the report that is being written by Clarkson and Gordon. Will we each have a copy of that report?



MR. TROTTER: In Ottawa standing on

July 1931.

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by Clarkson and Gordon. Will we each have a copy

of that report?



THE CHAIRMAN: The composite report being prepared, I would think so.

MR. TROTTER: I understand it is coming out in July. I wonder if you have any idea when we will obtain a copy. I think we should get one copy of that report since possibly it would assist us.

THE CHAIRMAN: Mr. Gadsby? Mr. Rice?

MR. RICE: We could enquire and see there will be sufficient copies made up.

THE CHAIRMAN: I imagine it would be in a couple of days. I think that is all.

MR. GADSBY: The hearing is adjourned until June 26, two p.m. in Committee room 1.

---Hearing adjourned at 4 p.m.



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W. R. Bryden

Select Committee on Drugs

HEARINGS

HELD AT
PARLIAMENT BUILDINGS
TORONTO ONTARIO

VOLUME No.:

24

DATE:

JUNE 26 1961

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SELECT COMMITTEE ON DRUGS

Proceedings of hearings
held at Parliament Buildings,
Toronto, Ontario, on Monday,
the 26th day of June, 1961,
at 2:05 p.m.

COMMITTEE:

MR. H.L. ROWNTREE, Q.C. -- Chairman

MR. A. WREN

MR. J.A. FULLERTON

MR. J. TROTTER

MR. R.E. SUTTON

MR. R.J. BOYER

MR. N. WHITNEY

MR. H.J. PRICE

MR. K. BRYDEN

MR. J. WHITE

MR. G.F. LAVERGNE

MR. S.J. GADSBY, F.C.I.S., Secretary

MR. HAROLD A RICE -- Committee Counsel

MR. W.J. AYERS -- Accounting
Consultant to the
Committee



/R/hm

---Upon resuming at 2.p.m.

THE CHAIRMAN: I have a matter I have been asked to deal with and there is some degree of urgency about it and I, therefore, will not be staying with the Committee this afternoon and I have asked Mr. Whitney if he would carry on.

---(Mr. Whitney takes the Chair)

MR. RICE: Mr. Chairman I am pleased to report to the Members of the Committee we have been successful in obtaining copies of the material which the Restrictive Trade Practices Commission in Ottawa will use in their enquiry and copies of this material has been distributed to the Committee.

This afternoon we have first Dr. H. E. Appleyard who is director of the Hamilton General Hospital. Will Dr. Appleyard come forward please? Doctor, for the purpose of the record will you state your full name please?

DR. APPLEYARD: Herbert Ernest Appleyard.

MR. RICE: Are you a medical doctor sir?

DR. APPLEYARD: Yes.

MR. RICE: And from what university did you graduate?



DR. APPLEYARD: Western Ontario.

MR. RICE: And what year did you graduate?

DR. APPLEYARD: 1930.

MR. RICE: And subsequent to graduation did you do any post-graduate studies or work?

DR. APPLEYARD: I did. In Vancouver and London, England. I was a member of the Royal College of Physicians in London; Fellow of the Royal College of Physicians in Canada; Master of Science of Columbia University in Hospital Administration and Fellow of American College of Hospital Administrators.

MR. RICE: And when did you get your degree in hospital administration?

DR. APPLEYARD: 1950.

MR. RICE: And I understand that you are the Director of the Hamilton General Hospital?

DR. APPLEYARD: Yes.

MR. RICE: How long have you held that position?

DR. APPLEYARD: About two and a half years.

MR. RICE: And what did you do prior to that time?

DR. APPLEYARD: I was superintendent of the General Hospital in Regina Saskatchewan.

MR. RICE: And how long were you attached to the hospital in Regina?

DR. APPLEYARD: Five years.



DR. APPLBYARD: Western Ontario.

MR. RICE: And what year did you graduate?

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of the General Hospital in Regina Saskatchewan.

MR. RICE: And how long were you

attached to the hospital in Regina?

DR. APPLBYARD: Five years.



MR. RICE: Were you associated with any hospital in an administrative capacity other than Regina Saskatchewan and Hamilton Hospital?

DR. APPLEYARD: Prior to that I was assistant director of the University Hospital, Cleveland Ohio three years.

MR. RICE: I understand you have a prepared brief or statement on behalf of the Hamilton General Hospital.

DR. APPLEYARD: Yes.

MR. RICE: Would you proceed to present it please.

SUBMISSION BY THE
HAMILTON GENERAL HOSPITALS
Barton Street
Hamilton, Ontario

APPEARANCE: Dr. H. E. Appleyard, Director

The Hamilton General Hospital operates three separate units in three physically separated buildings -

Barton Street Unit -	620 beds (medicine, surgery, pediatrics obstetrics and gynaecology)
Nora-Francis Henderson Unit	322 beds (medicine, re-habilitation)
Mount Hamilton Unit	215 beds, 150 bassinets (obstetrics, nurseries, chronic)
TOTAL	1307 beds



ORIGINAL DOCUMENT
NOT TO BE REPRODUCED

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Hamilton, Ontario

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three separate units in three physically separated

buildings -

Barton Street Unit - 620 beds (medicine,

obstetrics and
gynaecology)

285 beds (medicine,
re-habilitation)

Person Unit

Mount Hamilton Unit 215 beds, 150 bassinets
(obstetrics, nursing,
chronic)



These three units are all owned by the Corporation of the City of Hamilton and are under one general administration although physically quite separate. Each has its own pharmacy, all the staff being under the direction of one chief pharmacist who is located at the downtown Barton Street Unit but is responsible for all three pharmacies -

Barton Street Unit - 1 chief pharmacist and four full time and one half time other qualified pharmacists.

Nora-Frances Henderson Unit - 1 full time and one half time qualified pharmacists.

Mount Hamilton Unit - 1 qualified pharmacist.

Barton Street Unit also has 1 inventory clerk, 1 secretary and three porters.

At Barton Street Unit there is an organized out-patients' department with clinics in operation morning and afternoon, 5 days a week, with an average attendance of about 550 patients per week. Admission to these out-patients' department clinics is obtained only by means of a permit from the City Welfare Department (located immediately across the street). A patient must be judged indigent or nearly so by the Welfare Department before being permitted to attend the out-patients' department and he therefore gets free services and free medications as long as he attends the clinic. His permit must be renewed every three months - there are no paying or part-pay patients in the out-patients' department so that



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At Barton Street Unit there is an

organized out-patient department with clinics in operation morning and afternoon, 5 days a week, with an average attendance of about 250 patients per week. Admission to these out-patient department clinics is obtained only by means of a permit from the City Welfare Department (located immediately across the street). A patient must be judged indigent or nearly so by the Welfare Department before being permitted to attend the out-patient department and he therefore gets free services and free medications as long as he attends the clinic. His permit must be renewed every three months - there are no paying or part-paying patients in the out-patient department so that



the hospital derives no income of any kind from the operation of these clinics or for any drugs supplied to those patients (other than a Government grant for the V.D. Clinic and a Department of Health grant per visit). The costs of operation of these out-patients' department clinics are not paid by the Ontario Hospital Services Commission but are underwritten by the Corporation of the City of Hamilton along with the above grants. There is no corresponding out-patients' departments at either of the other units.

No drugs are sold by the hospital pharmacies to any patients in or out nor to employees and we therefore are able to purchase all our pharmaceuticals on a sales tax exempt basis.

Thus although geographically separated into three distinct units and although the types of cases treated in the three hospitals vary considerably and therefore the type of pharmaceuticals dispensed varies somewhat, our three pharmacies constitute just one department administratively with one chief and the same general policies apply equally in all units.

PURCHASE - The purchasing of drugs is done centrally for all three units. The chief pharmacist is responsible for ordering the drugs required, using his experience and detailed knowledge



of hospital usages as guides to quantities, forms and sources of supply. It is the individual physicians who order the drugs for their patients and the hospital must rely on the chief pharmacist to gauge the demand for individual items and to prevent as far as possible the accumulation of products in the pharmacy which do not move rapidly. The chief pharmacist makes the decisions but the actual placing of orders is done through the central purchasing office of the hospital.

We have ready access to large wholesale houses and to supplies of almost all our pharmacy requirements and ordinarily can count on obtaining adequate supplies of practically any required item and therefore do not have to build up too large a stock of any item simply to prevent being caught without it.

Some private formulae which we have specially made up for us can only be bought in certain minimum quantities e.g. 100 pounds or 100 gallons.

The quantity which we purchase of an individual item will depend on the quantity prices available, storage space available, and the shelf-life of the product. Our storage space is large enough to permit us to take advantage of quantity prices in most items. Some of the supply houses



make "special deals" available involving volume discount over and above the regular hospital discount. We take advantage of these special deals whenever possible. When not taken up it is usually because of the amount of cash involved or the amount of storage or special storage space available. We have two air-conditioned stockrooms which enable us to buy larger quantities of many items than would otherwise be practicable.



E/dpw

We do very little tendering for drugs. A certain amount of purchasing used to be done by tender but it has been felt over the last few years that we can do as well by taking advantage of quantity prices as they occur, keeping in mind the quality of the product which is the ultimate governing factor in ordering.

No loss is incurred due to out-dating or deterioration of drugs as our relations with the suppliers are such that they can always be returned for credit or replacement.

Until two years ago there was no active pharmacy committee of the medical staff and little attempt to standardize in any way or to control the items stocked in the pharmacies. Each attending physician was free to order whatever drugs he felt his patient required and the patient was charged for them. Since then, however, such a committee has been established by the medical staff and more than a year has been spent preparing the Formulary or drug list. This is now in its final form ready to go to the printers. It reflects the clinical judgment of the medical staff and will be under constant revision to keep it current. Its purpose is to standardize and control the stocks of medicines in the hospital pharmacies and is not intended to restrict the prescriber in his choice of drugs.

The items are all listed in groups according to their therapeutic actions and uses, under their



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The items are all listed in groups according to their therapeutic actions and uses, under their



official names with a description of their effects, chemical nature, usual dosage, available forms, etc. Official or generic names for drugs are given together with commonly used synonyms and trade names. To avoid duplication and stocking of many costly items, this will enable the pharmacist to dispense non-proprietary drugs of identical composition, purity and standard in lieu of Trade Name products unless there is no equivalent preparation listed in the Formulary. If any drug not listed in the formulary is specifically ordered by a physician and not carried in stock in the pharmacy, it will be obtained from an outside source and supplied to the patient. No drugs or preparations of secret composition will be approved for use in the hospital.

With this Formulary in use, the medical staff member will realize that when he prescribes by a proprietary name, the hospital pharmacy will dispense the same drug under its non-proprietary name if identical whether or not it is of the same brand referred to in the prescription unless the ordering physician specifically orders otherwise. It is anticipated that adoption of this Formulary will reduce the number of items stocked and make for a smaller inventory.

MANUFACTURING

In our pharmacies, we manufacture for use within the hospital only, certain ointments, lotions, tinctures, solutions and certain standard



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In our pharmacies, we manufacture for
use within the hospital only, certain ointments,
solutions, injections and certain standards



mixtures which are much cheaper to prepare than to purchase ready made. Due to the relatively smaller demand for these particular items, the pharmacy is presently manufacturing less of them than in the past. Because of the changing pattern of therapeutics the items which lend themselves to local manufacture are becoming less significant.

RESEARCH

To all intents and purposes no drugs are used for research purposes in this hospital except occasionally when a supplier provides an individual physician with a supply of some item for a specific clinical trial. In these cases there is no charge made to the hospital for the drug.

DISTRIBUTION

In the Barton Street Unit there are 22 wards. In the Mount Hamilton Unit there are 8 wards and in the Nora-Frances Henderson Unit 8 wards, each with a stock of basic drugs for the use of any patient on that ward. The operating room, emergency room and central supply rooms also have smaller supplies in stock at all times. Since drugs prescribed by the attending physician for in-patients are included in the standard ward care provided by the Ontario Hospital Services Commission, there is no longer any need for individual prescriptions for each patient and each drug as was the case when the patient had to pay for all these things individually. The number of



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items carried in stock on the wards varies greatly from hospital to hospital and in the Hamilton General it is somewhat larger than formerly. Each ward's stock can be replenished by delivery from the pharmacy daily of whatever is requisitioned to keep the stock up to normal. By maintaining a somewhat larger ward stock than formerly, extra trips to the pharmacy are less frequently required, particularly during the evening and night shifts.

The list of drugs kept on the wards varies with the type of ward, that is, pediatric wards have different stock from the adult surgical wards; maternity wards require different supplies from a male rehabilitation ward and isolation units' routine needs are different from the gynaecology ward, etc.

In addition to the ward stock of drugs, individual prescriptions are filled in the pharmacy when a physician orders something not kept on the ward. These items are delivered to the ward for the particular patient concerned and when he is discharged, unused drugs are returned to the pharmacy. Here they are returned to stock if useable or are discarded.

Drugs supplied to out-patient department patients are issued directly from the pharmacy on prescription from the clinic doctors. No stock is maintained in the out-patients' department. In general, only a sufficient supply of a drug is given to an out-patient to last until his next scheduled



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Drugs supplied to out-patient department patients are issued directly from the pharmacy on prescription from the clinic doctors. No stock is maintained in the out-patient department. In general, only a sufficient supply of a drug is given to an out-patient to last until his next scheduled



visit. Approximately 9% of the total drug costs in 1960 were applicable to out-patient department patients.

Narcotic drugs are strictly controlled in accordance with the requirements of Federal inspectors and there is an automatic stop order on all narcotics after 72 hours. A similar automatic stop order applies to all antibiotics after 7 days unless re-ordered by the attending physician.

ANALYSIS

No facilities are available for chemical analysis of drugs or pharmaceuticals received. We rely on the chief pharmacist's recommendations, based on his experience with the particular product and with the suppliers concerned. The same factors doubtless influence the practising physicians in their ordering of particular items for their patients.

STORAGE

As stated previously, adequate storage space is available to enable us to take advantage of quantity purchasing.

In the day time pharmacists are always available in all three units. Each night from 10 to 10.30 p.m. a member of the resident medical staff goes to the pharmacy to fill any prescriptions which have arrived since the pharmacy closed at 5 p.m. At other times the evening and night nursing supervisors have access to a key if they need to obtain any supply



Approximately 95% of the total drug costs in 1960 were applicable to out-patient department patients.

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An added advantage, adequate storage space is available to enable us to take advantage of

in the day time pharmacies are always available to all three units. Each night from 10 to 10:30 p.m. a member of the resident medical staff goes to the pharmacy to fill any prescriptions which have arrived since the pharmacy closes at 5 p.m. At other times the evening and night nursing supervisors have access to a key if they need to obtain any supply



from the pharmacy. (This does not apply to narcotic supplies). Apart from these and the night watchman, no one has access to the pharmacy or its storage areas.

A fire-proof storage room is used for keeping ether and other inflammable substances.

INVENTORY

As indicated above, the stock of drugs maintained for routine use on the wards varies with the types of wards. The amount of drugs stocked in the central pharmacy depends on many factors including the shelf-life of certain items, the rate of usage, bulk price factors, storage space available, etc.

Physical inventory is taken at year end only. A perpetual inventory is not maintained because the work and expense involved is not felt to be warranted. The total value of the inventory at year end of 1960 was \$95,309.00. This was rather high because of some large bulk purchases during the year because of the large number of similar items which have to be carried (which we hope will be alleviated by the formulary) and because we have three separate pharmacies duplicating each other's shelf stocks, and because we have over 40 wards or departments each with a stock of drugs for daily use.

ACCOUNTING

Drugs are entered in the hospital books at cost. No drugs are sold or charged for to



from the pharmacy. (This may not apply to some of the hospitals.) At the time of the first visit, the patient was seen for the first time on the day of the visit.

A list of the drugs used is given below.

As indicated above, the amount of drug used varies with the type of work. The amount of drug used in the control group was very low, the amount of drug used in the experimental group was very high, the amount of drug used in the control group was very low, the amount of drug used in the experimental group was very high.

Physical therapy is given at the time of the visit. A physical therapist is not available at the time of the visit. The total amount of the therapy at the time of the visit was \$5.00. This was not a very large amount of money for the time of the visit.

Because of the large amount of similar items used in the control group, the amount of drug used in the control group was very low, the amount of drug used in the experimental group was very high. We have no idea of the amount of drug used in the control group, but we have no idea of the amount of drug used in the experimental group. We have no idea of the amount of drug used in the control group, but we have no idea of the amount of drug used in the experimental group.

Drugs are given in the hospital. No drugs are sold or given for free.



any patient in or out. Following the system of the Canadian Hospital Accounting Manual our total drug expenditures include -

Anaesthetic agents

Intravenous solutions

Oxygen

Medicinal spirits

Drugs and pharmaceuticals

The cost of the anaesthetic agents is charged off to the departments using them (that is, operating room, emergency room, fracture room). The intravenous solutions are charged to the central supply room which issues them. Drugs supplied to out-patient department patients are charged to the out-patients' account. Oxygen is charged to in-patient care. The remainder represents the cost of drugs actually used for in-patient care, either as ward stock or on individual prescriptions. These figures for 1959 and 1960 were as follows:-

	<u>1959</u>	<u>1960</u>
Drug expenditures	\$346,186	\$397,985
Pharmacy salaries	62,415	63,078
Other direct pharmacy costs	<u>3,088</u>	<u>6,718</u>
TOTAL pharmacy costs (direct)	\$411,689	\$467,781
TOTAL hospital operating expense (inc. depreciation & debt charges)	\$8,581,515	\$9,619,911



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Medicinal solutions

Drugs and pharmaceuticals

The cost of the anesthetic agents is charged off to the department using them (that is, operating room, emergency room, fracture room). The intravenous solutions are charged to the central supply room which issues them. Drugs supplied to out-patient department patients are charged to the out-patients' account. Oxygen is charged to the patient care. The remainder represents the cost of drugs actually used for in-patient care, either as ward stock or on individual prescriptions. These figures for 1959 and 1960 were as follows:-

	1959	1960
TOTAL hospital operating expenses (inc. depreciation & debt charges)	\$8,581,515	\$9,619,911
TOTAL pharmacy costs		
costs		
Other direct pharmacy	3,080	6,715
Pharmacy salaries	62,415	63,078



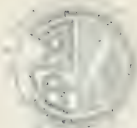
	<u>1959</u>	<u>1960</u>
Ratio of drug expenditures to total operating expenses (inc. depreciation & debt charges)	4.03%	4.14%
Ratio of drug expenditures to total operating expenses (excl. depreciation & debt charges)	4.33%	4.41%
TOTAL drug expenditures	\$346,186	\$397,985
Less oxygen 24,570		25,094
Less OPD drugs 29,288		35,520
Less anaesthetics 34,800		34,971
Less I.V. solutions <u>38,955</u>		<u>41,192</u>
	<u>\$127,613</u>	<u>\$136,777</u>
In-patient drug costs	\$218,573	\$261,208
TOTAL drug expenditures per patient day	.82¢	.93¢
In-patient drug expendi- tures per patient day	.52¢	.61¢

MR. RICE: Is there any way you could give us your figure as to the number of prescriptions this turnover of \$261,208 represents, or could you give us your average cost of a prescription to the hospital?

DR. APPLEYARD: The number of prescriptions was 192,087.

MR. RICE: That would be the prescriptions relating to this figure of \$261,208?

DR. APPLEYARD: Yes, at a cost of one dollar and thirty-five cents and a fraction, one dollar and thirty-five cents and a fraction.



	1930	1929
Ratio of drug expenditures to total operating expenses (incl. depreciation & debt charges)	4.14%	4.03%
Ratio of drug expenditures to total operating expenses (excl. depreciation & debt charges)	4.14%	4.33%
TOTAL drug expenditures	\$337,285	\$346,186
Less oxygen 24,570	25,094	
Less O.P.D. drugs 29,208	35,520	
Less anaesthetics 34,800	34,271	
Less I.V. solutions 38,955	41,132	
	<u>\$136,777</u>	<u>\$157,613</u>
In-patient drug costs	\$261,208	\$216,573
TOTAL drug expenditures per patient day	.934	.884
In-patient drug expenditures per patient day	.614	.524

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C/PE/hm

MR. RICE: That is your average cost then?

DR. APPLEYARD: Yes.

MR. RICE: That average cost, would that take anything into consideration for overhead?

DR. APPLEYARD: No.

MR. RICE: So that if one compared that price with the average cost of the prescription in a retail pharmacy, they would have to take all these other factors into consideration?

DR. APPLEYARD: Yes.

MR. RICE: But, it does include a certain amount of salaries for the pharmacists?

DR. APPLEYARD: Yes, and other direct pharmacy costs, being such things as uniforms and stationery and supplies issued to the pharmacy, and so on, but no indirect cost like overhead or insurance or heat, light and power.

MR. RICE: I understand you are presently proposing a formulary to be used in the hospital with a number of drugs to be used?

DR. APPLEYARD: Yes.

MR. RICE: Can you tell us how many different types of drugs you stored before you introduced this formulary plan or whether or not the plan has reduced the number of drugs and how many the number will be now?

DR. APPLEYARD: In the present



TORONTO, ONTARIO

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DR. APPELBYARD: In the present



Cardex system in which the stock is kept track of, in round figures, four thousand items in stock and they anticipate that with the formulary that it probably will go down to about twelve hundred.

MR. BRYDEN: How many did you say?

DR. APPLEYARD: Twelve hundred, approximately.

MR. RICE: And in terms of price, when you get this formulary system working, have you any estimate as to how that is going to affect your annual turnover of \$261,208.00 per year?

DR. APPLEYARD: No, I do not think I can give you a figure, sir. The saving will be in the bulk purchases on the supply of a particular item, rather than six different supplies for the same item. I can't give you an estimate.

MR. RICE: Do you expect that there will be a saving in the price?

DR. APPLEYARD: Yes.

MR. RICE: Of the turnover?

DR. APPLEYARD: Yes.

MR. RICE: Dealing then with that quantity discount for purchases of drugs, in your brief here, can you give us some idea as to how much of a drug would have to be purchases to get one of these quantity discounts?

DR. APPLEYARD: I think that varies with what the particular firm is selling at the



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MR. APPELYARD: Twelve hundred, about.

Maybe.

MR. RICE: And in terms of price, when

you get this formula system working, have you any

estimate as to how that is going to affect your

annual turnover of \$501,008.00 per year?

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time.

MR. RICE: Can you give us, in comparison as to what the standard retail pharmacists would carry, as to how much over and above that, his inventory, would you have to purchase to get a special deal on a quantity discount?

MR. SUTHERLAND: If I may answer that. My name is Mr. Sutherland. The outside firms might buy one hundred or five hundred; we might buy ten thousand. They come to us -- they do not have to but on the sales, one hundred at so much, five hundred at so much, five thousand at so much and if we can use five thousand in a reasonable length of time, we will buy five thousand. A retail store would not buy five thousand.

MR. RICE: The quantity discount you are referring to in your brief would be in that category?

DR. APPLEYARD: Yes.

MR. RICE: Perhaps you can ask your colleague, Mr. Sutherland, to answer this. If the retail pharmacist wished to deal in these large quantities, would he also likely be able to avail himself of these quantity discounts?

MR. SUTHERLAND: That is a debatable point. The retail men have been somewhat put out at us getting special prices. What would happen would be on the outside, five of them would go together



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and buy and they would buy maybe five or ten thousand if they dispensed enough of them in that particular time. As I understand it, they cannot buy those.

MR. RICE: Can you give us any idea as to the amount of this quantity discount; that is, from what the supplier to the retail pharmacist would normally purchase...? Can you give us any idea of that?

MR. SUTHERLAND: We will not buy quantity discount unless it exceeds seven per cent. It is usually ten or fifteen or sometimes twenty per cent.

MR. WHITE: Is that over and above the hospital discount?

MR. SUTHERLAND: No. If a hundred costs a dollar and if five hundred costs eighty cents, working it down, you get on ten thousand, it would cost you fifty cents. You would have a fifty per cent saving. I do not say that happens. That is just a rough figure, somewhere in between nothing and twenty or twenty-five.

MR. WHITE: Dr. Appleyard here said that the Hamilton General was enjoying volume discounts.

MR. SUTHERLAND: That is what I meant.

MR. WHITE: Beyond the hospital discount, and I thought that might be a special arrangement that, perhaps, a smaller hospital...

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your smaller hospital can't use it. Three of my friends are in smaller hospitals and they cannot buy this way and they are arranging for one of them to buy one item and another one will buy another one, and so on, and then they will trade back.

MR. WHITE: Is this volume discount a published discount?

MR. SUTHERLAND: Published as far as we are concerned.

MR. WHITE: Is it something that you have arranged?

MR. SUTHERLAND: No, we have not.

MR. WHITE: It is available to any hospital?

MR. SUTHERLAND: It is available to any hospital. It is not restricted to the Hamilton General. It is a question of how much can you buy.

MR. RICE: Is there a normal discount of hospital purchases supplied that is off the suggested retail?

DR. APPLEYARD: In many items, probably in most items, there is a hospital price which is less than retail.

MR. RICE: In drugs, it is customary for 40% discount; would that be about right, in Hamilton?



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D/EMT/hm

DR. APPLEYARD: It is as much as 40.
It may be less in some.

MR. SUTHERLAND: 50, and then when we
get into volume, we might run into 55 or 60.

MR. RICE: I think what Mr. White was
trying to establish, if you get a normal discount,
and if you go into volume buying, you get 10 to 25%
in addition to that?

MR. SUTHERLAND: May I say in addition,
they have items where the cost to us is ridiculous.
I will give you one instance. We buy an antacid
mixture, Amphogel. That **is** the trade name for an
antacid for a nervous stomach, and the doctor might
prescribe that. We buy it for 12¢ for six ounces.
It retails outside at \$1.35 or \$1.40 for twelve
ounces.

MR. RICE: Is there any explanation
you can give the Committee why there would be this
great variance?

MR. SUTHERLAND: They charge sales
promotion. If the doctor inside sees amphogel
around the hospital and sees it on the wards, and
possibly this does happen, the nurse may suggest
it because they have it, then this does influence
the man. They charge sales promotion on that.

MR. RICE: Do you find this type of
thing more prevalent in that type of drug, in trying
to establish a market, rather than some drugs that



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MR. RICE: Do you find this type of

thing more prevalent in that type of drug, in trying

to establish a market, rather than some drugs that



have been on the market for some time?

MR. SUTHERLAND: No, it happens with drugs that have been on for a long time. I don't say we have so many like them.

MR. WREN: You are calling this a loss leader?

MR. SUTHERLAND: In retail it would be called a loss leader, exactly.

MR. RICE: These quantity discounts and special deals, are you able to make those with the wholesalers as well as with the manufacturers, or do you usually make them with manufacturers?

MR. SUTHERLAND: Not with wholesalers. If the item is \$1.00 and the markup is 40%, that would make 60% cost from one dollar. The wholesaler works on 16-2/3. So if you were the distributor, one would sell a one dollar item to a wholesaler like National Drug, we would sell to them at 60¢ less 16-2/3, so that is the wholesale market. They must have a profit for handling and distributing. The volume discount is only direct.

MR. RICE: Has there been any checks by the Ontario Hospital Services Commission on the method of the Hamilton General Hospital in the purchasing and storing and so on of drugs?

DR. APPLEYARD: Not that I know of.

MR. RICE: Has there been any complaint by the Ontario Hospital Services Commission about



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DR. APPEYARD: Not that I know of.

MR. RICH: Has there been any complaint

by the Ontario Hospital Services Commission about



your method you have at Hamilton with regard to drugs?

DR. APPLEYARD: No.

MR. RICE: Have you had any complaints from the public or other people with regard to the drugs you use?

DR. APPLEYARD: No, not that I know of.

MR. RICE: I note on page three and four I believe of your brief that you refer there to supplying drugs of identical composition, purity and standard in lieu of trade name drugs where applicable.

Who decides whether the generic drugs are comparable and identical in composition, purity and standard, et cetera?

MR. SUTHERLAND: The same as when Mr. McCreary said when he was here last time, we rely on the honesty and integrity of the maker. How do we know some of the generic names or drug houses are not and do not have a high standard of integrity and honesty -- we would have to check.

Actually what it amounts to, you work your way into the market and establish those traits.

MR. RICE: I also understood at one hospital they are now soliciting letters of warranty or guarantee or something of that nature. Does the Hamilton General Hospital request any letter or certificate of warranty or guarantee with regard to the drugs that it purchases?

DR. APPLEYARD: From manufacturers, no.



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MR. SUTHERLAND: No.

MR. RICE: Is it very common in the practise of the hospital that the chief pharmacist or whoever substitutes the drug is called on to supply a substitute drug?

DR. APPLEYARD: We don't substitute for a drug unless the pharmacist contacts the physician who ordered the drugs and says we haven't got so and so, but we have the same thing under another name. Can I use that? And if the doctor agrees to it, the change is made. Otherwise we get the thing he orders. That happens occasionally.

MR. WREN: Will that ruling apply when you set up your formulary?

DR. APPLEYARD: No. The formulary, if it is approved by the Medical Board or the Medical Staff, if they agree this type of thing -- we haven't called it substitution; we call it supplying an alternative brand -- can take place. We will have one preparation which may have several brand names, and whichever brand name is ordered, we will give them the same substance, but not necessarily that brand name.

MR. WREN: Have any of the doctors of your staff voiced any serious objection to the formulary?

DR. APPLEYARD: Not as yet. It is just in the printing phase. We don't anticipate



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MR. WHITE: Will he be asked to fill out a form for that specific drug. Will the prescribing physician be required to fill out a form for the drug that he prescribes?

DR. APPLEYARD: He fills out a prescription for everything. He writes his order for everything.

MR. WHITE: If he doesn't want what is in stock, does he have another form to fill out?

DR. APPLEYARD: No, he can say so and so, no alterations. No substitutions.

MR. BRYDEN: That is one thing I wasn't quite clear from your brief. When the formulary comes into effect, would a substitution take place without consulting him if it was merely another brand of the same thing?

DR. APPLEYARD: As long as it is identical.

MR. BRYDEN: But he would have to specify right on the prescription that he wants no substitution?

DR. APPLEYARD: Yes.

MR. BRYDEN: Otherwise the pharmacist would simply go ahead and fill it with the identical product under a different name?

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which case there is no problem. It may be one of the others, and unless he specifies that particular one specifically, he will get whichever brand we have at the time. That is of course assuming the medical staff finally agrees to go ahead with this thing.

MR. BRYDEN: This has not finally been approved yet?

DR. APPLEYARD: All except the final formality of saying yes.

MR. BRYDEN: But the principle of it, they have already agreed to?

DR. APPLEYARD: Yes.

MR. RICE: Could you send a copy of that formulary to the Committee Secretary?

DR. APPLEYARD: When it is finished, sure, you bet.

MR. RICE: As a physician and as a man who has been associated with hospitals for a great number of years in an administrative capacity and so on, doctor, could you make any recommendations to this Committee as to how the price of the drugs could be lowered?

DR. APPLEYARD: As far as hospitals are concerned?

MR. RICE: Well, as far as the whole field of drugs.

DR. APPLEYARD: I don't know all the factors that go into the high prices, allegedly high



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prices.

MR. SUTTON: Do you think the prices today are high? Do you feel the cost of drugs is high today?

DR. APPLEYARD: The cost of drugs seems high, but I don't appreciate all the factors that go into it. Maybe some are not justified completely. As far as the hospital is concerned, in my own personal opinion, the formulary system would cut drug costs in hospitals considerably.

In the past when the doctor could order any item he wanted because the patient was going to pay for it, was tending to cause a lot of variety of items to pile up on the shelves and not move because other doctors weren't ordering the same thing.

I think a certain amount of education among the medical profession at large -- it would be a slow process -- that they should use the generic name rather than the trade name would certainly help. There are so many drug manufacturers and so many products on the market that no practising physician can know them all, and he does tend to do certain things with certain types, and perhaps does not always realize what possible alternatives there are to get the same results.

MR. SUTTON: Would you make that recommendation that the practising doctors use generic name instead of the brand name?



DR. APPLEYARD: Yes.

MR. WHITE: Are you going to encourage that?

DR. APPLEYARD: Yes. They will be listed -- the trade names will be listed, and in brackets --

MR. BRYDEN: The primary listing will be the official or generic name?

DR. APPLEYARD: Yes.

MR. RICE: Would a formulary similar to this one, could that be worked at the retail pharmacists' level? That is, a formulary for the retail pharmacist which the doctor could more or less conform to?

MR. SUTHERLAND: I think the retail man would welcome it. It would cut down their duplication because they have stock just like we do. They have stock items. I spoke to two English doctors that worked in England under the Health Plan, and they said for goodness sake don't have anything to do with the generic name. We can't remember them.

It is true if you and I were to manufacture a drug, it would be foolish for us to deal it to the doctor with a name ten letters long. We look for one with two or three or four or a word that describes the action of the drug, with some association of ideas so that he would remember.

Now, under our system of free enterprise, you would have to stop everybody doing that. Whether you could or not, I don't know.



MR. SUTTON: Which of you interview the detail men?

MR. SUTHERLAND: I do.

DR. APPLEYARD: The pharmacist.

MR. SUTTON: What is your opinion of the practise of the manufacturer's selling? The detail men? Is it a high pressure sales promotion job?

MR. SUTHERLAND: I think some of that comes into it. Let's say they have soft sale because when you get into this field initially you just can't force somebody in. You can't force a doctor to prescribe. All they are interested in is having the doctor prescribe.



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/dpw

I would say that they couldn't pressure doctors at the moment. I don't think any firm can do that, even the American type selling, which is that type of selling. I know detail men in Canada they were asked to take over a territory in the United States because they are Canadians and as a group, a sales group they do not sell in the hard way the Americans do.

MR. SUTTON: Would the detail men spend much time with you sir --

MR. SUTHERLAND: One day a week.

MR. SUTTON: -- when your own preference is for generic terms? I mean to say that he would be trying to sell you a brand name. You can say "I can buy the same thing less 40%, less 16½%". I mean you could knock his sales promotion into a cocked hat couldn't you?

MR. SUTHERLAND: Oh yes.

MR. SUTTON: How could a detail man sell you on a brand name when your preference is for generic?

MR. SUTHERLAND: But you see sir we can't prescribe the drug. We only dispense the drug. We must give what is asked for. If the individual doctors, in spite of the formulary, still ask for everything we have, we would still have to give everything we have. We will have no alternative. Generic names is one thing --



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MR. SUTTON: You are a registered pharmacist?

MR. SUTHERLAND: That is right, but I can't change the order of the prescription. I must give what is asked for. If they give me the generic name, I am wide open. I can give any one that I have, or any one that I care to buy and then the price would enter into it, of course.

Suppose three people who sold generic drugs came to us and they all had different prices, we would buy - would we buy the lowest price? Not always. We might buy it because we have more faith in one company than another.

MR. BRYDEN: When your formulary goes into effect there will be a strong tendency for you to, I presume, to have only the one brand or one manufacturer's product --

MR. SUTHERLAND: We will be glad to have that happen, yes.

MR. BRYDEN: I imagine the detailing is likely to get pretty fierce at that point wouldn't it? It would be a real advantage for any manufacturer to have his brand in your stock.

MR. SUTHERLAND: You are quite right. Mr. Black is the assistant chief pharmacist, and myself have been trying to work out an approach, and the only fair way for us to do it - if there are five big companies selling tetracycline, which



MR. SUTTON: You are a manufacturer

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Mr. Black is the assistant chief pharmacist, and myself have been trying to work out an approach, and the only fair way for us to do it - if there are five big companies selling tetraevoline, which



is a common name which we most all know, we will buy three months' supply from one and then maybe from another and maybe from another, and so on. How else could we be fair?

MR. BRYDEN: Would there be an advantage in trying to get them to bid against each other? They apparently don't.

MR. SUTHERLAND: There is an advantage, but I don't think it is a nice way of doing business.

MR. BRYDEN: The Federal Government does that. They ask them to submit tenders.

MR. SUTHERLAND: That is right. That would be a fair way. We would simply send them a letter and ask them to quote a price but we wouldn't play one detail man or one salesman against another.

MR. BRYDEN: No, I can see that. I was wondering, there will be a pretty substantial order for your supply in your hospital.

MR. SUTHERLAND: I don't think we would buy that far ahead although tetracycline has a two or three-year dating on it. I mean we could do it but don't forget our bills are paid by the Ontario Hospital Services Commission so if we buy too many items too far ahead we are using money from the budget which other departments - in other words, we just can't do that. I have spoken to our chief accountant and we can't go too far ahead.

MR. BRYDEN: Except that one of these



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MR. BRYDEN: Except that one of these



companies might agree to give you a price drop for a year's supply.

MR. SUTHERLAND: That is right sir. That would be an excellent thing. Then we might go a whole year with one company and if the other fellows are --

MR. BRYDEN: Then you have a better price next year. They can always quote a better price next year.

MR. SUTHERLAND: Quite possible, yes. And of course with the changing times, the drug that is popular today may not be popular next year so there might be - I don't know just what will happen, honestly.

DR. APPELYARD: The formulary system will lend itself to tendering much better than the present one.

THE CHAIRMAN: Have you had any experience of drugs supplied by generic names which were not found to be acceptable or which had qualities which influenced your opinion of the company supplying those drugs? Any criticism?

MR. SUTHERLAND: We have had no experience with generic drugs. You see you gentlemen I think in your minds have built up an idea that there is a generic drug and there is a proprietary drug. The proprietary drug is a generic drug. They have a brand name so it is easier to sell it.



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THE CHAIRMAN: That is true, but it has also been suggested that in the case of a proprietary drug which sells at a higher price, perhaps the pharmacist who purchases this drug at 40% off list price and he is asked to fill a prescription and even if a generic name were used, it has been suggested that it might be to his financial advantage to supply the more expensive drug rather than the cheap drug as his profit on the transaction would be much greater.

MR. SUTHERLAND: In retail that could happen. You could have two ways of acting; on the more expensive tetracycline make 40% on \$10 rather than on \$9. They could buy a cheap one, a very cheap one and still sell it for - to police this in retail would be very difficult. It wouldn't be so difficult to police it in hospitals. Dr. Appleyard at the moment would say you can't buy too cheap a drug or can't buy too dear a drug or someone else on the Committee - I am on that Committee too - tell me that we don't want you to go too low or too high. We want you to go somewhere in the middle.

THE CHAIRMAN: Have you had any experience in purchasing drugs from any manufacturer that you did become convinced of were not up to standard on price or they weren't up to standard, that persuaded you that perhaps the companies were not too reliable or any experience of that kind?

MR. SUTHERLAND: I have had no



THE CHAIRMAN: That is true, but it has also been suggested that in the case of a proprietary drug which sells at a higher price, perhaps the retailer who purchases this drug at 40¢ off list price and he is asked to fill a prescription and send it to a chemist name were used, it has been suggested that it might be to his financial advantage to supply the more expensive drug rather than the cheap drug as the profit on the transaction would be much greater.

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MR. SUBERBIAIN: I have had no



experience like that. I can say that we have - I recall one case of an injectable that we bought about five years ago and it is ordered by its name. It doesn't have a trade name. It's ordered by its generic name I should say and we tried one and it didn't stand up. I mean the product was fine for a certain period of time and then it didn't stand up. We found that with one of our tablets when we bought them on tenders some years ago so what we did was we bought less of it and used it up more quickly but if we bought a lot and it stood for any length of time, then it broke down; tablet, powder discoloured, and so on, and became unacceptable for people to take. That was the problem.

THE CHAIRMAN: Thank you.

MR. RICE: Are there any more questions from members of the Committee?

MR. TROTTER: I just had one question to ask. On the last page of your brief you make reference to in-patient drug expenditures. Does it cost more per day per a patient to give drugs to the in-patient rather than the out-patient?

DR. APPLEYARD: I am not sure if I understand your question. Per day is our unit for cost for patients inside and it is the total amount of drugs, or total number of patient days where we got this average figure of drug costs.

MR. TROTTER: Of course there are



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MR. THORP: Of course there are



drugs that go to the patient in the general hospital and then there are drugs that go to people who are outside the hospital but who come to the hospital.

DR. APPLEYARD: In the clinics, yes.

MR. TROTTER: To the clinic. Do the drugs cost more to the patient or to those who are in the hospital or to those who come to the clinic?

DR. APPLEYARD: They would be roughly the same. It might be a shade more per individual to the out-patient. I am just thinking because they are more likely to be getting special things and not the ordinary daily routine aspirin and sleeping tablets that the in-patients get. They are not getting laxatives at night; not getting the simple routine things that in-patients are all getting which brings the cost of the in-patient drugs down.

MR. TROTTER: I often wondered about the average price per day per patient for drugs. Isn't there a tremendous variance in price, or the cost of drugs to a person? A lot of patients may not have any drugs at all and then other patients will take an awful lot?

DR. APPLEYARD: Yes.

MR. TROTTER: So that is the average cost really a true picture, let us say, of the expense to a person or individual?

DR. APPLEYARD: No, in the last figure there, in patient drug expenditures per patient day



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of 61 cents some patients will have 10 cents; others will have \$5; depends on what they have, how much of it may be antibiotics. Sometimes they have three or four antibiotics at once because we try - one seems not to be working, desperately ill, may use a shotgun arrangement of several drugs. Some would take very expensive drugs; other people would take very very little drug expenditure.

MR. TROTTER: I have had drawn to me certain examples where an individual might be a patient, in this instance of a mental hospital and receiving certain drugs. Once they are released from a hospital they don't get the necessary drug. As a result, they are back in the hospital. Do you have many instances, or any instances even in a general hospital of that type?

DR. APPLEYARD: Not that we are aware of, no. The indigent people, the welfare people who are in-patients when they go home are referred to the out-patients' clinic and they go in and carry on with their drugs which are provided free by the City. There is no need for them to have a gap in their treatment.

MR. TROTTER: A person on welfare would not have a gap like that because I daresay you watch the situation.

DR. APPLEYARD: If a person is leaving the hospital today, Monday and their next clinic



Appleyard

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is Thursday we will give them to take home enough of the drug to last them until Thursday when they come into the clinic and then they get a fresh supply at the clinic. A person is perhaps less likely to have a gap than a private patient.

MR. TROTTER: The only person who would fail to get the drugs they needed, after they have been discharged, is someone who is not on welfare, just on the fringe of it but still not on the welfare?

DR. APPIEYARD: If the patient does not get the drugs it is either because the doctor has not told him about it or has not ordered it or the patient did not go to the store and get them.

MR. TROTTER: Is it necessary to be on welfare to go to the clinic of the hospital?

DR. APPIEYARD: It is in Hamilton General, yes. It's a city policy and once they get there because they are welfare it is all free.

THE CHAIRMAN: Doctor, on the last page of your brief we notice that there is an increase in the drug expenditure per patient day both in in-patient drug expenditure and on the total drug expenditure. Would you ascribe that increase to increased use of drugs or to increased price list of drugs or would you say that increase has been progressive over the last few years? That it has been increasing gradually, that there is a general trend towards the increase in the price of drugs per patient day?



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DR. APPLEYARD: I think it is a combination, sir, I think it is partly increased usage and I think it is partly the fact there are more drugs available now every year that weren't available last year, and they tend to be more expensive because they are newly developed. They tend to be in the antibiotic group which is used -- the antibiotic drugs are used much more than they used to be. They are the expensive ones.

THE CHAIRMAN: Has there been any great reduction in the price of drugs, of certain specific drugs in the last year or so?

DR. APPLEYARD: I would have to ask Mr. Sutherland.

MR. SUTHERLAND: That is right, the big seller in Canada in antibiotics is chloromycetin. This is coming down, I think from fear. You see few other companies have patents, they are on the market and undersold chloromycetin which had the field to itself for ten years or more. They reduced the price. In fact when we bought -- we bought a year's supply at roughly 50% price. It was \$30.00 and something a hundred. We bought at \$15.00 or \$16.00. They went down by the appearance of Horner and Intermedical.

THE WHITNEY: Would you also, Mr. Sutherland, agree with Dr. Appleyard that it is the new drugs and the increased usage of drugs that is largely responsible for the fact that the drug cost



DR. APPELBYRD: I think it is a complaint-

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Sutherland, agree with Dr. Appelbyrd that it is the new drugs and the increased usage of drugs that is largely responsible for the fact that the drug cost



per patient day is increasing?

MR. SUTHERLAND: Yes, I would think so. It is the case of a man building a better mousetrap and he goes out and sells it. Also, to be really serious about it, they find new drugs for common usage. In other words, if somebody could find something better than aspirin for a headache and brought it on the market, it would sell, wouldn't it?

THE CHAIRMAN: That is true. We had heard of the price of drugs being decreased, coming down some and still and all the reductions of the price of drugs haven't been sufficient to alter that trend, that is the trend generally speaking is up. Do you feel that has been sort of constant over the past several years?

MR. SUTHERLAND: Yes, it has been practically constant since I have been with the Hamilton General, the last ten years. It means they bring a new drug and still use the old one. One would think if they brought out a new drug they would stop using the old one, but there is only one of the antibiotics, the one that was practically the first one on the market, chloromycetin, is practically obsolete as far as internal use is concerned. It is still used in ointments. That is the only one I can think of of all the antibiotics -- they are all used. One would think if a drug superseded another, the one superseded would drop off the market. It doesn't.



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It may drop 75% or 50%, but you still have to carry it, still have to have them and still use them, carry them with the new drugs. It would add to the cost. That is what happens.

THE CHAIRMAN: Thank you.

MR. WREN: In your experience as a professionally trained administrator, what would you say would be the smallest size of hospital to adopt a formulary?

DR. APPLEYARD: I don't think the formulary principle is limited to any size. I think small hospitals could use it.

MR. WREN: If you were in a 50-bed hospital, would you recommend it?

DR. APPLEYARD: The same principle could be used.

MR. WREN: I mean the principle.

DR. APPLEYARD: I think the biggest factor to get a formulary is the education of the doctors. They are the people who order the drugs they want, not the pharmacist. If the doctor -- it is like, a doctor used to be taught to order drugs in grains and ounces. Now it is in the decimal system. The one trained in the older system still talk about grains and ounces, and always will. It takes quite a while to change from one to the other. If all doctors could think along the lines of generic names it would be just as useful to a 50



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bed as to a 500.

MR. WREN: In our Class C and B hospitals, the smaller hospitals in the Province, they could consider, perhaps, zoning the province and setting up formularies where the doctors in those areas would be familiar with the economies that could be affected.

DR. APPLEYARD: Theoretically, one formulary book could be applied in any hospital in the province.

MR. BRYDEN: Would it be possible to work from one formulary for all hospitals operating in the province, or all general hospitals?

DR. APPLEYARD: I think so, provided the physician or doctor could go outside the formulary if he needs to.

MR. BRYDEN: I think every formulary I have ever heard of, that principle has always been recognized, but apart from that, it would seem in logic what is good enough for the Hamilton Hospital ought to be good enough for any hospital.

DR. APPLEYARD: Surely.

MR. SUTTON: Has the Ontario Hospital Services Commission shown any interest in this idea of yours?

DR. APPLEYARD: Not that I know of, not actively.

MR. SUTTON: They didn't actually assist you in setting up or suggesting the drugs.



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MR. WHEAT: In our Class C and B hospitals

the smaller hospitals in the Province, they could consider, perhaps, zoning the province and setting up formularies where the doctors in those areas would be familiar with the economies that could be effected.

DR. APPLEBY: Theoretically, one formulary book could be applied in any hospital in

the province.

MR. BRYDEN: Would it be possible to work from one formulary for all hospitals operating in the province, or all general hospitals?

DR. APPLEBY: I think so, provided the physician or doctor could go outside the formulary if he needs to.

MR. BRYDEN: I think every formulary I have ever heard of, that principle has always been recognized, but apart from that, it would seem in logic what is good enough for the Hamilton Hospital ought to be good enough for any hospital.

DR. APPLEBY: (SPEAKING)

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DR. APPLEYARD: No.

MR. WREN: You are a medical doctor
yourself?

DR. APPLEYARD: Yes.

MR. WREN: Do doctors, do you feel that
doctors would welcome this sort of programme in
general across the province?

DR. APPLEYARD: I think the great bulk
of them would accept it -- well, yes. There would
still be some who may want to order specific things.
That is what they are accustomed to.

MR. WREN: It would be a professional
help to them?

DR. APPLEYARD: I think so.

MR. RICE: Does the Hamilton General
Hospital belong to the Ontario Hospital Association?

DR. APPLEYARD: Yes.

MR. RICE: Does the Association favour
a formulary for its members?

DR. APPLEYARD: I am not sure whether
the Association has gone on record on that or not.

MR. RICE: Has it been discussed or
is it being discussed in the Association, do you know?

DR. APPLEYARD: It has been discussed
with individual members. I don't know whether the
Association as a group has discussed it officially
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MR. DILLON: Could I speak?



DR. APPELBYARD: No.

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MR. DILLON: Could I speak?



MR. RICE: Would you identify yourself for the record, please?

MR. DILLON: My name is H. G. Dillon. I am here for the Ontario Hospital Association. I am assistant to Mr. Martin, executive secretary-treasurer of the Association. I am on a watching brief, Mr. Chairman. In answer to your last question, the subject of formularies is being discussed in Committee by the Association. There are no findings, but it is one of the active agenda items at the present time.

MR. BRYDEN: It is a fairly new idea as far as the Ontario Association is concerned?

MR. DILLON: I think as far as the programme is concerned, Mr. Bryden, it is comparatively new. I have no figures, but I understand it isn't very extensively used in any event.

THE CHAIRMAN: Thank you.

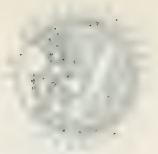
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MR. TROTTER: Dr. Appleyard, do you find that the doctors at the present time in the hospital object when the pharmacist will dispense a different drug than is ordered?

DR. APPLEYARD: The pharmacist doesn't do that unless he phones the doctor first.

MR. TROTTER: They are allowed to do it in your hospital, are they not?

MR. SUTHERLAND: Only when the formulary becomes active, not yet. They phone the doctor and



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MR. SUTHERLAND: Only when the formulary

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get his permission to make a change.

MR. TROTTER: Would you find from your experience that patients tend to obtain hospital space, space in the hospital in order to get the drugs free?

DR. APPLEYARD: I don't think I know of any cases where I suspected a patient tries to get in the hospital to get free drugs.

MR. TROTTER: I am thinking of an instance such as a doctor had a patient who knew the drug bills would be high and the patient didn't want to go on welfare, so the only way to cut costs down to that individual was to put them into the hospital. Do you not come upon that?

DR. APPLEYARD: There may have been some. I don't know of any. They would only get it free while they were in. We wouldn't supply them after they went home.

THE CHAIRMAN: That would depend largely on the integrity of the doctor.

DR. APPLEYARD: It would.

THE CHAIRMAN: The doctor would have to state the patient required hospitalization, wouldn't he?

DR. APPLEYARD: It depends to some extent on the availability of beds. If there is a bed shortage the more urgent cases are let in.

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information, it used to be that the matron in the



hospitals, the matron was the final authority on admission of patients. Who is the final authority now?

DR. APPLEYARD: On admission of patients?

MR. WREN: Yes.

DR. APPLEYARD: The final authority is the availability of beds.

MR. WREN: Assuming the beds are there.

DR. APPLEYARD: If the beds are available?

MR. WREN: Yes.

DR. APPLEYARD: The attending doctor, who sends it in must submit the diagnosis, what he is sending it in for. If there is a bed available the patient comes in. Beds are short in Hamilton. When a person comes in, if the doctor states it is emergency, it comes in anyway without any questions about the admission. It is admitted as an emergency so it will be checked after to see how genuine these emergencies are.

MR. WREN: Difficulties arise from time to time where doctors are listed as staff and only members of the staff may admit a patient. What remedy does a patient have if a doctor refuses to admit him?

DR. APPLEYARD: The patient wants to go to the hospital and the doctor won't send him in?

MR. WREN: That is right.

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MR. WREN: I am thinking of a case where the doctor didn't even look at the man, he said on the telephone he is still talking and still walking, so he doesn't have to go to bed.

DR. APPLEYARD: I think a patient would probably get another doctor.

MR. WREN: Where would he get another doctor if only a doctor on staff could admit him?

DR. APPLEYARD: He could get another doctor who is on the staff. You are referring, I presume, to a closed staff hospital?

MR. WREN: Fairly, yes, pretty well.

DR. APPLEYARD: He would have to go to another doctor on the staff or go to some other hospital.

MR. WREN: He went to a hospital 70 miles away and he nearly died on the trip. There was no one he could appeal to -- not he, he wasn't capable of arguing but his friends.

DR. APPLEYARD: That is true of the Hamilton General, a patient can be admitted only by doctors on the staff, but practically every doctor is on the staff in one capacity or the other, so to all intents and purposes all the doctors in the City are on the staff.

MR. SUTTON: How many doctors have you



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MR. SUTTON: How many doctors have you



on staff?

DR. APPLEYARD: Something over 400.

MR. SUTTON: Are there any of the 400 that have disapproved of this formulary?

DR. APPLEYARD: Not specifically yet, no.

MR. SUTTON: Unanimous?

DR. APPLEYARD: No, no. It is being handled so far by the Medical Board, which is a 25, 24 member committee which manages the medical affairs of the staff, and they have approved the principle of the thing.

MR. WREN: It is a majority vote, is it?

DR. APPLEYARD: Yes.

MR. WREN: Simple majority and it is applied to all the staff.

MR. BRYDEN: When do you expect it will be operating assuming all goes well.

DR. APPLEYARD: End of the summer, probably.

MR. BRYDEN: So it will be a couple of years before you are really in a position to make any definite estimates as to its saving you any money?

DR. APPLEYARD: Yes.

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DR. APPLEYARD: As far as that factor, but there will still be all the other factors, the new drugs et cetera.

THE CHAIRMAN: Any further questions?

Thank you very much Dr. Appleyard, Mr. Sutherland. We certainly have appreciated it.

MR. RICE: Mr. Chairman, on the agenda Mr. Peter Smith, the Administrator of the Woodstock General Hospital was to appear this afternoon. Unfortunately we have received word he is ill and he will be ill for a couple of weeks. However, he has sent his brief along. If you like I will read it into the record or you can have it taken into the record as read and if any members of the Committee wish to ask questions we can arrange with the secretary to have him come up at a later date. If there are no questions his brief will be on the record.

THE CHAIRMAN: That will be quite all right. All right.

MR. RICE: Do you wish me to read it or take it into the record as read?

MR. BRYDEN: Have you read it to us. We will never read it. You had better read it.

THE CHAIRMAN: Yes, if you would read it. We have had a short afternoon.

MR. RICE: I will proceed then to read the brief of Mr. Peter Smith of the Woodstock General



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Hospital, which is a Class B hospital.

Honorable Gentlemen in presenting this brief I would justlike to outline my professional background. From 1929 to 1934 I was apprenticed in the profession of Pharmacy. 1934 to 1936 I attended the Ontario College of Pharmacy graduating with the degree Bachelor of Pharmacy. From 1936 to 1941 I was engaged in retail pharmacy. In 1941 joined the Abbott Laboratories, one of the largest manufacturing and research pharmaceutical companies in the world, as a Medical Service Representative. Following seven years in this capacity I was transferred to the hospital division of the company. For seven years I was in charge of hospital service for the Province of Ontario. During this time I gained a wide knowledge of the operation of a hospital, with the problems involved. In 1955 I applied for the position as Hospital Administrator at Woodstock General Hospital, a position which I still hold. During the thirty years I have been connected with the Profession of Pharmacy this question of Drug costs has been almost a constant problem, from the days when the profession was accused of charging exorbitant prices for coloured water until our present time when the many so-called Wonder Drugs with their high prices are creating a hew and cry across the country.

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Smith

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I will therefore give you a detailed outline of the Pharmacy department at Woodstock General with its relationship to the Medical Staff, Patient Care and Hospital Budget.



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With the opening of the new hospital the pharmacy was organized under proper lines. A representative stock of the more commonly used drug specialties was set up. The charges were still based on the retail list price.

A Pharmacy Committee was set up to control the policy pertaining to this department. We do not operate an organized outpatient department nor do we have Interns at our hospital. The only so-called Staff or Indigent patients are those covered by our city or county welfare departments. For these reasons it is not practical to have a Drug Formulary which restricts what drugs may be prescribed by the doctors on our medical staff. However we have agreed to and set up a Drug Index. This lists



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in alphabetical order all the Drug specialties carried in stock in the Pharmacy. A copy of this is at each nursing station thereby allowing the doctors to refer to it and prescribe what is already in stock rather than cause duplication. This Drug Index is revised every three months when new items are added. The decisions pertaining to this Index are completely in the hands of the Pharmacy Committee.

As everyone knows there are new drug products being announced every day. To permit our physicians to prescribe what they wish for their patients an arrangement has been set up with a local retail pharmacy to supply these items in small amounts on a twice a day delivery service. When these items are in sufficient demand they are then added to our drug list and are purchased in the quantity most economical for the hospital. Routine purchase of drugs is handled by the Pharmacy. The bulk of our purchases are on a direct basis with the manufacturer. Quantity prices are taken advantage of when economically sound. We have an arrangement with our suppliers whereby unbroken packages of drug items are returned for credit when they are no longer being used in our hospital. This helps to keep our inventory at an optimum level.

Drugs are dispensed for individual patient use from order slips written by the Head Nurse on the floor. These are copied from the



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official doctors "Order Form" which is kept on the patients Chart. Non-dangerous drugs which are reasonably priced are issued in bulk for floor stock. The quantity issued is strictly controlled and periodic spot checks against patient drug orders are made. The items in this list are drugs such as, Laxatives, Aspirin, Compounds, Phenobarbital, etc. Many bulk drugs are also dispensed to the floor which must be charged to the Nursing Service as it would be impossible to make individual charges for them. These include Back Rub Lotion, Skin antiseptics, Rubbing alcohol, etc.

Charges for Drugs are made daily as they are issued and these are then computed on a monthly basis to arrive at a drug cost per patient day. As drugs are purchased they are charged to inventory and an adjustment is made at the year's end. A review of our drug costs per patient day for the years 1957-58-59 and 60 with the first four months of 1961, reveals an interesting picture.

1957 - 95¢ 1958 - \$1.02 1959 - \$1.12 1960 - \$1.07

For this year to date \$1.01. From these figures we can construct a graph. 1957 saw the change from Penicillin products to the more expensive wide spectrum Antibiotics. 1959 increase was the result of the all-inclusive system under the Ontario Hospital Services Commission.

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oriented into the OHSC Plan, I feel sure that we have returned to a normal balance in drug therapy.

The physical layout of our pharmacy is such that all required drugs are readily available. Drugs requiring temperature control are kept in a special refrigerator. Dating on perishable drugs is checked routinely on a weekly basis.

Our Pharmacy is operated for in-patient service only and sale of drugs to out-patients or staff is discouraged except in a case of emergency.

While we have an excellent hospital laboratory as well as a pharmacy with qualified staff we are unable to carry out routine tests for purity or to do biological assays on drug products. For this reason we have made a practice of purchasing drugs from companies who have such facilities as well as an established reputation in the pharmaceutical industry.

Possibly this method of production is expensive. I do not wish to go into the details of this but a few observations are imperative. Our hospital is not opposed to the use of Generic nomenclature being used by our physicians. There is however, the problem of who is to educate the doctors as to what the complex Generic name is and as to how he is to remember it. "Trade names" are usually simple short names which are easily remembered. We have found that our doctors usually pick out one of



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these and stick to it. This is why we have the agreement that a brand name does not restrict our pharmacy from filling the prescription with the identical drug of equal quality made by another manufacturer under a different name.

This question of "quality" always creates a problem. I do not wish to imply that only products made by certain established Drug Houses meet the requirements of the British or American Pharmacopeas. However, as pointed out, our hospital is unable to carry out controls for potency and therefore we feel that until the government establishes sufficient control centres to do this for us that we would not wish to take the responsibility for drugs of unknown origin. Particularly those originating in European countries where we know that drug standards do not compare with our Canadian.

We have discussed the possibility of controlling in some way any doctor who may seem to abuse the use of drugs by prescribing more than the average for our hospital. Our Pharmacy Committee and also our Medical Executive Committee agree that this cannot be done while the OHSC has an all-inclusive per diem rate. We also felt that since we seem to be maintaining a good cost level that need for discipline was not present.

There is another factor which proves interesting to this committee. I have pointed out



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fore we feel that until the Government establishes
sufficient control centres to do this for us that we
would not wish to take the responsibility for drugs
in European countries where we know that drug stan-
dards do not compare with our Canadian.

We have discussed the possibility of
controlling in some way any doctor who may seem to
abuse the use of drugs by prescribing more than the
average for our hospital. Our Pharmacy Committee
and also our Medical Executive Committee agree that
this cannot be done while the OHSC has an all-inclu-
sive per diem rate. We also felt that since we seem
to be maintaining a good cost level that need for
discipline was not present.

There is another factor which proves
interesting to this committee. I have pointed out



our graph for drug costs has returned to a constant level. Parallel to this is the fact that our length of patient stay has only increased from 8.9 days in 1958 to 9.6 days for both 1959 and 1960. It would seem that we are fortunate at Woodstock in having a more or less stable community which is co-operating with the hospital in caring for the sick and are not abusing the service just because of the OHSC Plan. This applies to both the patients and the physicians.

This, Gentlemen, gives you a brief outline of Pharmacy as it applies to the Woodstock General Hospital. I would like to now make a few observations about hospital pharmacy costs in general.

Duplication of Products beyond all reason should be controlled if possible.

If the cost of advertising material could be reduced it may be possible to pass along this saving to the consumer.

An example of the problem of "Generic Names" may be given at this time.

A product commonly prescribed as DBI. This is a board of Phenformin. The Generic name would be N.B Phenyl-Bi-Guamide. If any of you Gentlemen were required to prescribe this drug, which name would you like to have to remember? I agree that all names are not as complicated, but many of them are. One more point we must keep in mind when questioning the cost of drugs. While many of the newer drugs are



expensive because of the research expense and production costs, the companies producing these drug specialties must continue to supply many Galenical drugs which have been used for years. The prices of these drugs products have not risen with our national inflation and I feel that in many cases the drug specialties may be carrying the cost of these other products.

Examples of these are:-

Atropine Sulphate Tablets	Calcium Lactate Tablets
Cascara Tablets	Ferrous Sulphate Tablets Quinine Capsules etc.

In recent years some drug distributors have chosen the top volume product of many companies and offered them for sale, while not offering any of the low volume or low price products. This gives them in my mind, an unfair advantage. In conclusion I would like to mention the medical research carried on by the ethical Pharmaceutical Companies. Even a hospital of our size is supplied with much clinical material by drug companies. I can think of a few from the past couple of years. A new anti-coagulant drug to control post coronary blood clotting time. A high potency Cortisone suppository for the treatment of ulcerative colitis. A new product for the control of cholesterol levels in the blood. These materials were supplied no charge both to the hospital and to the patient. Reports of the results were sent to the manufacturers so that they would be



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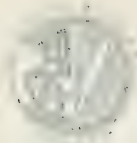
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correlated with other reports from other investigations to properly evaluate the drug before it is released for sale.

Such research costs money!!!

If we restrict the profit making incentive which such research produces medical progress could be set back many years. In looking at the drug costs we should keep in mind that we are purchasing the therapeutic value of the product not just the bright coloured capsule or tablet. I hope, Gentlemen, that this report will help you in your research just as our hospital reports help the Pharmaceutical manufacturers and that you will be able to arrive at a just and fair conclusion.



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/dpw

THE CHAIRMAN: Thank you, Mr. Rice.

Is there any discussion by the Committee resulting out of this brief, or do you think it would be advisable to endeavour to have Mr. Smith here at a later date?

MR. BRYDEN: It would seem to me, Mr. Chairman, we had other gentlemen cover much the same ground. I doubt if we could get much more by putting Mr. Smith to the trouble of coming here.

THE CHAIRMAN: I am rather of the same opinion myself. We certainly appreciate the preparation of this brief. I believe he was here before, and we did not have time to listen to him. I think Mr. Gadsby should write him and thank him for his efforts and tell him that the Committee appreciated his brief very much.

MR. GADSBY: Yes, sir.

THE CHAIRMAN: Is there anything further, Mr. Rice?

MR. RICE: No, Mr. Chairman, that concludes the representations we had on the agenda for this afternoon. Tomorrow afternoon at 2 o'clock I think we have Mr. Solomon who is a retail pharmacist operating the Islington Royal York Pharmacy. Also we have Mr. J.B. Keating who is operating a pharmacy in the Guelph area.

MR. TROTTER: I believe now we are going to deal with pharmacists on Tuesday, and I



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also understand on Wednesday, and while we are in this line of questioning, I wonder if it would be possible for our Secretary to send a letter to the man who operates the pharmacy at Honest Ed's. I think there was some controversy about it earlier in this hearing. Mr. Norman Englander is the man who I found actually operates it, and if we could have him give his view on the retail drugs. I think we have been consistent in the various types of pharmacists we have been hearing; there has been the small pharmacy, the large pharmacy and chain stores, and I was wondering if we could write a letter to speak here. It is Honest Ed's pharmacy - or anybody else from that company.

THE CHAIRMAN: I think Mr. Gadsby will be quite pleased to endeavour to include that on the agenda at the proper time, and it may be filled in with our meetings.

MR. WREN: One other matter I was interested in I was up north since the last meeting, and I noticed a news item that two doctors had been convicted on a charge laid by the College of Pharmacy for dispensing drugs. Some Toronto --

MR. BRYDEN: Clinic, in Toronto.

MR. WREN: That seems contrary to what we have been told in this Committee that doctors can dispense - in fact we have had doctors here who were dispensing.



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MR. GADSBY: They can dispense, but the people filling the prescriptions were not qualified under the Pharmacy Act.

MR. WREN: Oh, that was it? I wonder if our counsel could get a report on that.

MR. RICE: Yes, I will check and do that.

MR. WREN: Maybe the news item was not adequate, I don't know, but it appears to me they were convicted for dispensing drugs, as doctors.

MR. RICE: I will check on that.

MR. GADSBY: Not being qualified under the Act to fill prescriptions.

MR. WREN: The impression one got from the newspaper, they were convicted of dispensing illegally, which certainly our understanding of the law is they are perfectly entitled to. However, if they were using other people, I suppose, to dispense --

MR. GADSBY: The last newspaper clipping went into it in some detail and gave the reasons.

MR. RICE: Even newspapers can give the wrong impression.

THE CHAIRMAN: Gentlemen, our meeting is concluded. We will resume tomorrow at 2 o'clock, and we will have the agenda, so we will adjourn now.

--- The hearing adjourned at 3.45 p.m.



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MR. FARR: Yes, I will check and so

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VOLUME No. ~~25~~ DATE:

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SELECT COMMITTEE ON DRUGS

Proceedings of hearings
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the 27th day of June, 1961,
at 2 p.m.

COMMITTEE:

MR. H.L. ROWNTREE, Q.C. -- Chairman

MR. A. WREN

MR. J.A. FULLERTON

MR. J. TROTTER

MR. R.E. SUTTON

MR. R.J. BOYER

MR. N. WHITNEY

MR. H.J. PRICE

MR. K. BRYDEN

MR. J. WHITE

MR. G.F. LAVERGNE

MR. S.J. GADSBY, F.C.I.S., Secretary

MR. HAROLD A. RICE -- Committee Counsel

MR. W.J. AYERS -- Accounting
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MR. H. J. PRICE

MR. K. BRYDEN

MR. J. WHITE

MR. S. J. GADREY, B.C.I.S., Secretary

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MR. W. J. AYERS -- Accounting Consultants to the

Committee



/dpw

--- On resuming at 2 p.m.

THE CHAIRMAN: Mr. Rice?

MR. RICE: Mr. Chairman, this afternoon we have two practising pharmacists who will make representations to the Committee.

First we will have Mr. J.B. Keating, who is a practising pharmacist in Guelph, Ontario.

Would Mr. Keating come forward, please.

Mr. Keating, have you any prepared statement you wish to make to the Committee?

MR. KEATING: Yes, I have, Mr. Rice.

MR. RICE: Before you make it, would you tell us what your full name is?

MR. KEATING: James B. Keating.

MR. RICE: What is your occupation?

MR. KEATING: Retail pharmacist.

MR. RICE: Where do you carry on business?

MR. KEATING: In Guelph, Ontario.

MR. RICE: How long have you carried on that type of business in Guelph, Ontario?

MR. KEATING: I have been in business for 22 years.

MR. RICE: At the same location?

MR. KEATING: Well, the one location, and another location for eight years.

MR. RICE: And you are a licensed



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MR. KEATING: Well, the one location,

and another location for eight years.

MR. RICE: And you are a licensed



pharmacist practising in Ontario?

MR. KEATING: Yes.

MR. RICE: What is the population of Guelph?

MR. KEATING: Around 40,000.

MR. RICE: Whereabouts in Guelph do you carry on business? In the central part of the city?

MR. KEATING: What you call the so-called downtown district.

MR. RICE: Would you proceed to present your statement?

MR. KEATING: Thank you. Mr. Chairman and members of the Select Committee, before I start on some of my prepared brief here I think that there are a couple of things I would like to bring to your attention which were referred to when I was here the last time, and that is there was some question of the cost to the pharmacist and I think somewhere around \$10,000 fee, or at least what it would cost the pharmacist. I have had it drawn to my attention that you should look at it in another way. A thirteen grade student in four years would surely earn \$10,000 and another \$10,000 for cost of education, so actually the cost of the pharmacist runs closer to \$20,000.

Another thing, apparently, Mr. Chairman, you asked three members of the retail pharmacists who were here questions regarding the open sale of

pharmacist practicing in Ontario?

MR. KEATING: Yes.

MR. RICE: What is the population of

Quebec?

MR. KEATING: Around 40,000.

MR. RICE: Whereabouts in Quebec do

you carry on business? In the central part of the

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antibiotics through feed stores. I contacted Dr. Glover, secretary of the Ontario Veterinary Association, and from him I received a copy of the brief. Now, this is a lengthy brief, but here are the five reasons they set forth, and then their brief goes on to prove it.

"This memorandum is submitted by the Ontario Veterinary Association with reference to the proposed relaxation of restrictions on the sale of certain drugs through commercial outlets for the feeding or treatment of animals.

Public acceptance of what are often called 'wonder drugs' has tended to obscure public understanding of the problems which arise in the use of antibiotics, and there is little public recognition of what was termed in the British Medical Bulletin of January, 1960, as 'The Dangers of Antibiotic Treatment'. If these were understood, there would probably be a demand for more rather than less control over distribution.

Studies by a Committee of this Association, including members who have long been engaged in research and scientific work, lead to the following conclusions:

1. Comparative experience in the United States and the United Kingdom illustrates the need for caution in the distribution of antibiotics.

2. The excessive use of antibiotics



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1. Comparative experience in the United States and the United Kingdom illustrates the need for caution in the distribution of antibiotics.
2. The excessive use of antibiotics



tends to stimulate the development of resistant strains of bacteria.

3. The discriminating and effective use of antibiotics requires qualified professional judgment.

4. The antibiotic treatment of animals without adequate control may have direct or indirect effects on human health.

5. The cost of antibiotics, indiscriminately used in treatment or in feed mixes, would be a drain on the livestock industry without corresponding economic gains.

The reasoning in support of the above-stated conclusions will be set out in summary form seriatim.

MR. SUTTON: Did you say he was the secretary of the Ontario Veterinary Association?

MR. KEATING: No, the brief submitted to the Ontario Government by the Ontario Veterinary Association. That is Dr. Glover.

MR. SUTTON: Is his brief in opposition to the sale of antibiotics through --

MR. KEATING: Yes. It is a brief similar to what the pharmacists put in. Mr. Donaldson particularly mentioned it to me. He was sorry he couldn't give some of the answers to the questions you asked him.

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Another fellow, gentlemen, I hope so.



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MR. SUTTON: Before you leave this question of antibiotics, have you any views of your own in the excessive use of antibiotics, say, by a farmer, treating it himself?

MR. KEATING: I am not in the antibiotic, so-called veterinary pharmaceutical business. Being in Guelph it is rather strange, but they go to the college and get advice from the college and then come back and pick up the medication. The only thing I know is that talking to some of the - for instance, the Co-op. Milk Company, they ran into a lot of trouble with milk coming in with strains of penicillin in the milk and they couldn't use it.

MR. SUTTON: These products are put out by the American Monsanto.

MR. KEATING: That is one. There are some, of course, restrictive sales.

MR. SUTTON: These antibiotics are chemicals. If you treat a cow with this chemical it comes out in the milk.

MR. KEATING: I think they have ways of checking the milk to find out. I am not too sure about that. They know they can at the Co-op.

MR. SUTTON: Isn't it true that the farmers want this product handled by a qualified druggist?

MR. KEATING: Not necessarily by the



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MR. SUTTON: After the prescription is written for the use of it they would come and buy it from the drugstore. This is another source of revenue, isn't it?

MR. KEATING: It is not a source of revenue actually; it is part of our function in dealing with medication.

MR. SUTTON: Safeguard.

MR. KEATING: Yes. So we can follow the laid-down provincial laws, and so on and advise the people of the dangers inherent, and so on.

THE CHAIRMAN: I suppose if they found traces of penicillin in the milk that it might be we would have fluoridated milk.

MR. KEATING: Well, gentlemen, I just want to say that I more or less concur in the brief presented by my colleagues that preceded me.

Now, I made some prepared notes here, but just to put you at ease I am going to talk a bit about hospital pharmacy. I don't want you to think I am going into the wrong field, but the two are tied in, and I think one of the questions was the cost of drugs to pharmacies and so on, and I think something in the eye of the public has been the thought of someone standing behind the counter, but to get the true picture, with the new students qualified as well as the old, with their extra



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extension courses, with the hospital pharmacist you get a better picture.

MR. RICE: Perhaps to explain to the Committee, have you any association with a hospital?

MR. KEATING: Yes. I am Chairman of the Advisory Board of St. Joseph's Hospital, and I have been since its inception in 1950, and previous to that for five years I was a Commissioner on the Board of the Toronto General. I have seen these two hospitals go from 100 beds, no administrator, no pharmacist, to 176 beds, with a pharmacist, school of nursing, and St. Joseph's Hospital from 100 beds, no pharmacist, to 214 active treatment beds, 109 chronic, 121 in the home of the aged, a total of 444 beds, operating their central supply with a full-time pharmacist, also the school of nursing. In both hospitals we have a pharmacy, there is a therapeutic committee working, and this may be unique or not, but we hold joint meetings of the Pharmacy Committee in both hospitals four times a year, and this is some of the work that is done. I will just read it.



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R/dpw

In this district the two hospitals hold joint meetings of the Pharmacy Therapeutic Committees, though each hospital has its own committee. Four meetings yearly, special meetings when indicated at each hospital alternately. Administrator not a member, but may attend on invitation. Each institution has chairman, three physician members, and a pharmacist who acts as secretary, takes minutes and looks after correspondence, enquiries to other hospitals, universities or institutions regarding drugs, or reports.

2. Recommendations emanating from Committee are passed on to specific bodies affected; those concerning therapeutics to the medical executive to be passed on to medical staff members; those which affect hospital operation to the administrator; decisions affecting nursing care to the director of nursing, etc.

3. At the P. & T. Committee meetings new drugs are considered which are believed significant, the pharmacist supplying necessary technical information, references, etc. The Committee decides what course pharmacist will take in stocking such items. If drug is known to have a potential value, minimum stocks are purchased with the understanding that each hospital will call on the stocks of the other institution while drug remains new and expensive. The same practice prevails regarding many



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day-to-day dispensing needs; borrowing from the other hospital cuts costs involved in purchasing from retail sources.

I might add here gentlemen two hospitals in Guelph with about 600 beds, there is a little hospital not very far away with 34 beds. I don't sell to the hospital but I talked to another pharmacist who does. He says this little hospital buys three times as much as the two combined.

THE CHAIRMAN: Is that dollar value?

MR. KEATING: Dollar value. I am speaking roughly.

4. Also discussed at the P. & T. Committee meetings: such matters as prescribing of drugs in dangerous doses. The pharmacist refers individual cases to the prescribing physician, but if undesirable trend is noticed, the pharmacist refers this to the committee and receives its authorization to publicise the dangers in question by means of a staff bulletin or notice and the committee in turn transmits a recommendation to the medical executive.

5. Recent meetings covered the following:

a. Medical literature has lately focussed attention on undesirability of including Folic Acid in multiple vitamin preparations.

In purchasing new stocks should we insist on deletion



day-to-day dispensing needs; borrowing from the
other hospital cuts costs involved in purchasing
from retail sources.

I might add here gentlemen two hospitals
in Guelph with about 600 beds, there is a little
hospital not very far away with 34 beds. I don't
sell to the hospital but I talked to another person
that who does. He says this little hospital buys
three times as much as the two combined.

THE CHAIRMAN: Is that dollar value?

MR. KATZ: Dollar value. I am

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of this fraction of the B-Complex by the pharmaceutical manufacturers?

b. Some physicians prescribe aminophyllin for small children. The pharmacist is of opinion that this drug is dangerous in these cases. What does the Committee think? The pediatrician on the P. & T. Committee recommended that such preparations should be used with caution, particularly in children under two, and the Committee instructed the pharmacist to publicize this information by bulletin to the medical staff.

c. Combination of Sparine and Demerol - Sparidol is the trade name, not generic - is being ordered by physicians in both hospitals. The pharmacists ask the support of the Committee in refusing to supply this combination since the components are available separately (policy of hospital pharmacy dictates that no combinations will be supplied if the same effect may be obtained by the use of the components separately). The pharmacists were authorized to refuse to stock the item in question.

d. There was a discussion of generic names. All agreed that the pharmacist should supply the brand of her choice, providing products of good therapeutic potency be chosen.

e. The recent disaster involving acid solutions was discussed and a recommendation drafted whereby no solutions of this drug will be



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Solid solutions was discussed and a recommendation
granted whereby no solutions of this drug will be



stocked on the floors or maintained in the pharmacy, but will be prepared extemporaneously when ordered.

Here are some specific rulings incorporated by the Committee.

In groups of drugs where a multiplicity of preparations are available (e.g. vitamins, antibiotics, etc.) the Committee authorizes the pharmacist to stock one or two types in each classification (usually the same in both hospitals) and the medical staff is aware of this fact in prescribing such agents. This practice enables the pharmacist to buy economically (because of greater potential) the best brands obtainable in these fields, thus ensuring the patient good therapy.

No drugs of secret composition are stocked: no patent medicines.

A new drug not yet passed by the Committee will be supplied from local sources for individual cases but no stocks will be purchased. A physician may submit a request that a specific drug be stocked and the pharmacist will relay this request to the Committee for their decision.

7. A recent survey has been instituted by the Royal College of Surgeons involving rulings for administration of intravenous solutions, blood, etc. by graduate nurses. Also included in the study was the question of the addition of certain drugs to the intravenous solutions in

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question. (This study was doubtless prompted by recent notification from the nursing profession organizations in the U.S.A. to the effect that nurses there may now give I.V. solutions and blood). At a meeting of the medical executive the pharmacist was required to make recommendations on this point, preparing a list of drugs which she believed could safely be added to I.V. solutions by nurses. Only specially trained graduate nurses may undertake this technique, however, and in no case may she administer whole blood. The pharmacist is required to continue recommendations in this matter.

And that is just a picture of a pharmacy at work.

THE CHAIRMAN: It also indicates a high degree of co-operation between the two hospitals.

MR. KEATING: Yes. It is a very well organized committee. I think the citizens are quite happy the way they work together. Now we get back to the other items. I have one observation I would like to make. To the best of my knowledge there is no pharmacist employed in purchase, distribution or administration of potent drugs in Ontario Provincial Institutions except in two instances. I believe one is St. Thomas. That is a large hospital operated by the Provincial Government who have a hospital pharmacist. I think it would be an advantage if they could see their way to using more pharmacists.



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The Ontario Hospital Services Commission has no pharmacist employed within the framework of its administration. This Commission is the largest purchaser of drugs in the Province, or I should say at least they pay for them.

A pharmacist at administrative level could do much in giving guidance to hospitals on drug purchases.

When this Select Committee of the Legislature of Ontario on Drugs concludes its hearings, I would like to see them make three recommendations to the Legislature which could save the citizens of Ontario I think an inestimable number of dollars in drug purchases.

First I would like to see the Pharmacy Act amended so as to include hospitals. This means a pharmacist in charge of every hospital dispensary. Right now you are thinking where can we get part-time pharmacists for small institutions? I am sure the College of Pharmacy through their extension services could set up a short course to train pharmacists in small areas in special hospital pharmacy techniques. To the best of my knowledge this has already been discussed in the College Council circles.

In some small retail areas of Ontario the local retail pharmacist is practising at the hospital on a part-time basis now. Two: I would



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like to see the appointment of a pharmacist to the Provincial administrative level in the department in charge of Provincial institutions and hospitals.

Three: appoint a pharmacist to the administrative offices of the Ontario Hospital Services Commission.

Pharmacists in the retail section of the profession in Ontario maintain an up-to-date file on all new drugs. The busy physician is using this service more and more every day, consulting with the pharmacist about new drugs, their dosages, their actions. This is occupying much more of our time and this will continue to increase with the multiplicity of new drugs.

Page No. 2465 follows



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Angus, Stonehouse & Co., Ltd.



Pharmacists do not view their profession with disinterest. They are keenly aware of the contribution pharmacy has made to the public health over the centuries.

The pharmacists with higher educational standards contribute much more to the public health needs. We stand ready, gentlemen, and willing.

That is the conclusion of my formal remarks.

MR. RICE: Mr. Keating, perhaps you could give us some information about your own practice of pharmacy in Guelph what would be the value of your stock of drugs.

MR. KEATING: In drug stock?

MR. RICE: Yes.

MR. KEATING: I think about \$8,000.00.

MR. RICE: And what would be your annual turnover in drug stock?

MR. KEATING: That would be roughly about three and one half times, that is dispensary stock you are asking me about?

MR. RICE: Yes, drugs within use of the terms of reference.

MR. KEATING: I am combining two stores here.

MR. RICE: You have more than one location, have you?

MR. KEATING: Yes. Do you want one?

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MR. RICE: Will you break it down for us?

MR. KEATING: I have an inventory of 4,000 in one and probably about 12 prescription sales, that is three times, and the gross profit on that alone is \$6,000.00, and I pay my pharmacist more than that.

MR. RICE: How many different drugs would you carry in your stock, that is different brands of different drugs as well?

MR. KEATING: Do you mean you want a breakdown as to items you are classifying? You mean, for instance, do you want one item. It could be 25,000. You just want one item?

MR. RICE: Yes, one item. If it is stocked by a different manufacturer, that is two items.

MR. KEATING: I would have to guess at that, sir. I think it would be around 1,000 items, roughly, in the dispensary, but that is just a hazardous guess.

MR. RICE: Could you give us some idea of the number of prescriptions that you dispensed, say, during last year?

MR. KEATING: That is including everything?

MR. RICE: Yes, the total number of prescriptions.



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MR. KEATING: That would be around 5,000, 5,000 to 6,000, 5,500.

MR. RICE: Is that for the two stores?

MR. KEATING: No, that is just one. I am just stating one.

MR. RICE: And what personnel do you have at that store?

MR. KEATING: I have a pharmacist in charge that I relieve on his time off, and I have three ladies as clerks.

MR. RICE: Could you give us any idea as to what the average cost of the prescription would be, the 5,000?

MR. KEATING: Do you mean to the patient?

MR. RICE: No, the cost to the public.

MR. KEATING: That is the public. That is what I meant by the patient. It is between \$2.50 and \$2.75.

MR. BRYDEN: How long does this pharmacy stay open? How many hours in a week?

MR. KEATING: We have a rotating system which is pretty hard to define. Let us put it this way: My store was open this Sunday from eleven o'clock until eight o'clock. It is open from nine until eight this week every night, and nine o'clock on Friday. But the next three weeks that store won't open Sunday. It will close at one



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that store won't open Sunday. It will close at one



o'clock on Wednesday and it will close at six o'clock every other night except Friday and it will be open Friday until nine.

MR. BRYDEN: And there is always some pharmacy open?

MR. KEATING: On Wednesday in Guelph there are only two pharmacies open in the whole city, and there are sixteen stores there. There are two open all day and the neighbourhood stores work a different schedule. There are two stores open downtown every night and two in the neighbourhood open until eight every night, and on Wednesday there are only two stores open and on Sunday two stores plus a couple of others stay open two or three hours.

MR. RICE: Whereabouts do you purchase your drugs for the retail pharmacy?

MR. KEATING: Drug Trading Wholesale and some are purchased direct from the manufacturers.

MR. RICE: And what discounts do you receive when you purchase from the manufacturers?

MR. KEATING: Around 40%.

MR. RICE: That is 40% off?

MR. KEATING: Yes, that is net.

MR. RICE: And Drug Trading is a wholesale outfit?

MR. KEATING: Yes.

MR. RICE: And what discount do you receive from them?



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MR. KEATING: It is about 33-1/3, and one company we get 40% off wholesale, and some run as low as 25%. It is a varied figure but I would say 33-1/3, roughly, is the average.

MR. RICE: And you get a rebate from Drug Trading Company?

MR. KEATING: Yes, it is a co-operative company.

MR. RICE: Could you tell us what that rebate would average out to in relation to the volume of purchases, what percentage of your volume of purchases?

MR. KEATING: 10%, yes, on what you purchase from Drug Trading.

MR. RICE: Yes, that is what I mean. You recover back about 10%?

MR. KEATING: Yes, some items are excluded from that, but pharmacies are all in it.

MR. RICE: Can you return drugs to the manufacturer or Drug Trading that you don't use?

MR. KEATING: No drugs can be returned if the package is open. We can return some drugs if we purchase them through Drug Trading, and the traveller of that pharmaceutical house is in our store and he writes out an order and takes it back to Drug Trading. Other pharmaceutical houses that we deal direct with, have travellers who will pick them up and send them or expect us to package them



up and mail them in. But that is on items that are out of date or become obsolete. It is not a big factor, but it is important.

MR. RICE: Do you have a write-off for wastage or unused drugs that you cannot sell or get rid of?

MR. KEATING: Yes we do.

MR. RICE: How much would that be?

MR. KEATING: Well, if you carefully watch your returns to the manufacturer -- I think the write-off factor of drugs is not too great, about 2%.

THE CHAIRMAN: Do you have any observations to make as to whether prescriptions are too large in size, in quantity?

MR. KEATING: Do you mean the doctors write too much?

THE CHAIRMAN: Yes.

MR. KEATING: No, Mr. Chairman, if anything I often think the doctor has not written sufficient sometimes. But, on the other hand, the doctor is proceeding with a certain amount of caution and he does not want to load up. I would say that if anything he is on the under side with that, because that is always my feeling that they will need more than this, but that is with a new case and not if it comes up again.

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MR. TROTTER: Do you think the doctor



may order a smaller quantity because he fears the drug will cost his patient too much?

MR. KEATING: I don't think so. I think it is this way: The doctor -- I don't mean he is doing a trial and error, but there is always the thought that, "I will use some of this" -- not an antibiotic, they shoot it right to him, but on some of the others, I think the doctor is going to use this. If this works out, all right, he will buy this or that quantity. But, on the other hand you know yourself there are things that you have and it is not just proving to be a good cure, but I would say that the doctor prescribes because there would be no point in him prescribing an expensive drug and not prescribing enough. That would defeat its purpose, wouldn't it?

MR. TROTTER: The reason I asked that is that I have had the impression from some doctors that they prescribe a small quantity knowing their patient can only pay so much, can only pay so much until next payday, and then they refill it the next payday when he will have some more cash.

MR. KEATING: That is a new one to me.

MR. RICE: Mr. Keating, when you set your price for a prescription, can you tell us the method, how you calculate your price that you are going to charge for a prescription?

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Keating

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MR. RICE: It would compare simply to that chart.

MR. KEATING: Yes, of which our fee is 75 cents - I think it is a 50-cent fee if I am not mistaken.

MR. RICE: On your account, prescription account, that fee isn't reflected as a separate item, is it?

MR. KEATING: No.

MR. RICE: It is included in the sum.

MR. KEATING: All-inclusive, yes.

MR. TROTTER: Do you think it would be a good idea if you had a breakdown of your fee, so much for the drug and so much for the labour?

MR. KEATING: I didn't think so before coming to the hearing. I am beginning to change slightly my thinking and go along with your thinking. I wouldn't like to make an open statement on it yet. Actually, I have spoken against it, but now I am beginning to change slightly. I am going to look into it more.

MR. RICE: Have you had many complaints, or many complaints from the public with regard to the price they have to pay for prescriptions from your retail pharmacy?

MR. KEATING: I have had one or two occasions, but if you take the time to explain it to the customer, although generally speaking the doctor



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briefs him and says it is going to cost you quite a bit. This is what you need. When we first - this goes back two or three years that we had complaints, but the public now are learning, at least, are more or less used to the higher prices of some of the antibiotics and so on.

MR. RICE: Did you find when you explained it to the customers that they generally accepted your explanation?

MR. KEATING: Yes.

MR. RICE: And go along with the price?

MR. KEATING: I have had no trouble that way. In fact, they rather appreciate having it explained to them rather than dropping something else and handing it to them.

MR. RICE: Would you more or less classify the nature of complaints of the public regarding prices in that situation, that it is lack of information by the public as to what makes up or how the account is calculated?

MR. KEATING: I think so, Mr. Rice. I think that there is this image business. That is why I brought up the hospital pharmacy. They look on the pharmacist who hands out the prescription among all this other merchandise - when you hand out a prescription, unfortunately, you are in that, cluttered up with this merchandise and people attach - get that so-called image. When the people realise



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the function of a pharmacist - another thing people don't realise, supposing a doctor writes a prescription for a baby, atrophine, one grain, and the pharmacist fills it and the baby dies - the doctor is absolutely in the clear. I just bring this up, a responsibility we hold to the public. It is probably a thousandth of a grain that is the proper dose there.

The public, I think, are beginning to realise more that we are professional people. Our course has gone up from one to two to four years. I believe Mr. Hughes gave a good brief on the advancement of pharmacy, and there is still advancement, I think, through education. The people are beginning to realise more and more that the pharmacist is a professional man in the community. We are not running into the difficulty and we are going to run into it less.

MR. BRYDEN: The pharmacist tends to destroy that image, which I think is the correct one, by running all the general merchandise.

MR. KEATING: Yes, but that is gradually being overcome. I think in retail there has been a terrific change, not in all, but in the last ten years there has been a terrific upgrading of retail stores. In the stores today in a great many cases you walk in and the professional pharmacy department stands right out. I think that is why we are gradually coming up in the public eye. We are making



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that the heart of our business instead of a little small bit of it. I think that is what we have to do and we have to do more. I mean, we are partly to blame, but we are bringing that out and the public are being educated, as it were. Even in some of the large plazas you will walk in but you will find that the pharmacy department is the focal point in that great big 10,000-foot store.

MR. WREN: From some of the evidence we have heard the pharmacist is making little or no money on the overall operation and it would appear that some of them use the pharmacy as a lure to get the people in to buy the general merchandise. Would that be a fair observation?

MR. KEATING: My comment on that, Mr. Wren, is, from what I read and from my own pharmacy which is a general pharmacy, one of the best ways to get prescription business is to act professionally and maintain a good pharmacy and the other is to create a good store. People keep coming back to you and the more you are going to do the dispensing for these people. The two tie together.

MR. SUTTON: You said you are losing money.

MR. KEATING: I have just pointed out that if I didn't operate a retail store, Mr. Sutton, my profits from the prescription department would just about pay the pharmacist's salary. If I didn't



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operate that retail - that doesn't take in the first aid supplies and sickroom supplies and all that.

That is straight prescription. If I didn't have that operation along with that I couldn't maintain that store in that location just with prescriptions only.

MR. SUTTON: As to the question of discount, you said you got 40% from the manufacturer and you said you got 33.1/3% from Drug Trading but that Drug Trading pay an additional 10%. Why would you do any business with the manufacturer at all if you get 43.1/3%?

MR. KEATING: 33 1/3% plus an additional 10 figures about 40%.

MR. SUTTON: Just 40%. Would you buy anything at all from the manufacturer except when he brings out a new drug and sends his detail man around to see you?

MR. KEATING: Some manufacturers we buy direct from, from the detail man on the territory and we get drug shipments of new drugs that come in from them.

MR. SUTTON: It would be mostly the new products.

MR. KEATING: Not necessarily.

MR. SUTTON: It is to your advantage to deal with Drug Trading, isn't it?

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in some cases the pharmaceutical manufacturer - there are three or four companies, it is to our advantage financially and otherwise to deal with them.

MR. SUTTON: In larger quantities?

MR. KEATING: Yes.

MR. SUTTON: Get a larger discount?

MR. KEATING: Not that, for instance some firms Drug Trading can give you only 25% on.

MR. SUTTON: On some items?

MR. KEATING: Some firms that operate that low. They have no wholesale policy. They only have a direct policy.

MR. WREN: Getting back to the professional aspect of it, do you think Guelph would be served better by fewer professional pharmacists full-time rather than 60 pharmacists operating part-time; that is to say, part of their time in the pharmacy and the rest in general merchandise.

MR. KEATING: When I went to Guelph some 20 years ago, this is an illustration, we had eight stores downtown. We were about 23,000. I said the population is forty now. That doesn't take in the college area. They don't come in. Actually it is higher, a little higher than forty. We have now, I think it is eight stores, one at the college and one a way out. They are all operating pharmacies. Some of them are a mile-and-a-half to two miles from the downtown district. Supposing



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we said these eight were going to be able to service the people of the community. They would have to go a long way for pharmaceutical service. They are covered by the many stores and service.

MR. WREN: There are other sections of the Province that can't get pharmacists because there are not enough of them.

MR. KEATING: Of course, if there is never a guarantee of dispensing only - you would have your store.

MR. WREN: I just wondered if there was some way, the professional spending so much of the time in general merchandise rather than professionally.

MR. KEATING: That is why I brought out that part in my statement, if something was done with the Pharmacy Act, with hospitals under the Pharmacy Act, the pharmacists in the communities would benefit if they were - I don't propose - if small hospitals went to the pharmacy I think it would direct more people to the profession of pharmacy and the Province would benefit by it. That is why I feel very keenly about this one point. You would be assured of this professional service.



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E/BL/hm

MR. RICE: Mr. Keating, would you tell us the prescriptions, the average prescriptions, how many prescriptions you get in your retail pharmacy are written in the generic form and how many in the trade or brand name form?

MR. KEATING: Not many in the generic names. There are a few, but we have not run into that too much in Guelph.

MR. RICE: Unless they are written in the generic form the pharmacist would have little control over the prescription?

MR. KEATING: We are more or less dictated to by the prescription.

MR. RICE: And if you followed your formula with regard to calculating your account, the price of your prescription, and the doctor writes the prescription, you would have little control over the end price of the prescription?

MR. KEATING: That is quite true. But, on the other hand, on the therapeutic committee, the doctors there in both hospital more or less go along with medicines of known therapeutic content from a quality control laboratory, and that is one of the reasons they don't run into it.

MR. RICE: Do the hospitals in Guelph sell prescriptions to out-patients?

MR. KEATING: No.

MR. RICE: I am interested in your



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MR. RICE: Do the hospitals in Dublin

MR. KEATING: No.

MR. RICE: I am interested in your



recommendations to the Committee. Would you expand on those to the Committee and explain how they affect the price of drugs, or are these just recommendations perhaps to make the distribution more convenient?

MR. KEATING: Well, the Committee as a whole will determine the findings here. Although in Guelph it is proven what the pharmacists functioning in a hospital can do, I feel with all your great government institutions, and so on -- and I am speaking not as an oldster but for those who are newer and in the last sixteen years, they don't have to rely on the sales, they know drugs and where they come from, and I am sure they could be of great value to the province. The same with the Ontario Hospital Services Commission. We have no pharmacists at the administrators level. I think, going along with the little example in Guelph, he could co-ordinate or give advice to the little hospitals and tell them: "I think you are doing the wrong thing; you could get better medication here and a better price."

MR. SUTTON: Buying through the Hospital Services Commission, buying large amounts might mean that the pharmacist would lose a lot of business.

MR. KEATING: That wasn't my point. I think it is just more or less an administration of pharmacy so that it could be carried on, because

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they could still buy, each hospital, setting up their own pharmacy.

MR. SUTTON: If you buy in larger quantities the discounts are much larger, and the question has been asked several times: Why is it that our own Hospital Services Commission in the drug business actually buying drugs and distributing them to all these hospitals?

MR. KEATING: I think it would be under controlled therapy then, because you couldn't just have a controlled provincial therapy. But I was thinking of a pharmacist at the administrative level. You might have a hospital here, say, the hospital services might be 4%. I am just taking this figure out of the air. No, I think I have it here in this hospital. Supposing the average for the province is 4%, and here is a hospital where their drug costs are 9% or 10%, and they would be all channelled to that pharmacist. In situations a way out of line he could go and do something probably to help them. It wasn't central buying, because that would be the last thing we want because we couldn't have central therapy.

MR. RICE: Do you think that the Commission's pharmacist could devise a formula for the smaller hospital?

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ministration, the same way we have done.

MR. RICE: I believe you indicated, Mr. Keating, that the system you have developed in Guelph between the two hospitals where they can borrow from each other and have a limited stock has cut the cost of the price of drugs. Could you give any indication of how much, how far the present drugs have been affected by this system?

MR. KEATING: Those are figures I could get from the hospital. I didn't bring them down with me. I don't want to speak for the hospital, but I know that the saving is this way: One hospital probably carries a bulk of a certain item and another hospital carries a minimum stock. If you can cut your inventory \$5,000.00 or \$10,000.00 a year that is another consideration, there is less money tied up. Another thing is that if the two hospitals combine together and buy a product they usually get a better discount.

MR. RICE: I am just wondering if you could give us how much it would affect it. Cut it in half?

MR. KEATING: No. Most of the hospitals buy the same as we do less 11%, and there are cases where they might do something for promotion and they might want it used in the hospital. But I find now there is not nearly so much of special manufacturers' prices in hospitals. There was a few years ago. In



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1959, the Ontario Hospital Services Commission, 7.8% of their expenditures was in drugs, medical and surgical supplies. I am sure that the pharmacists could help a lot in that administration.

MR. RICE: In Guelph is there a common method for calculating or determining the price of the prescription? Is your system a common system?

MR. KEATING: In most cases. There are two or three stores which don't follow it exactly, I think, but most of them follow the 75¢ fee plus the breakdown.

MR. RICE: Have you any other recommendations that you can make to the Committee as to what this Committee could do which would affect the price of drugs?

MR. KEATING: Well, I think that the price of drugs as far as the public is concerned is, say, education will overcome it greatly. But I don't think that this great cry about using generics, without quality control, and so on, I don't think there is much differential in the price in the first place. I can't think of anything to recommend, because we go along and use drugs of known quality control, and there isn't the differential there used to be.

MR. RICE: Mr. Chairman, have you or any other members of the Committee any questions to ask Mr. Keating?



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used to be.

MR. RICE: Mr. Chairman, have you or any other members of the Committee any questions to

ask Mr. Keating?



MR. TROTTER: Mr. Keating, do you come across many cases of your customers who just can't afford to buy drugs, that is cases of hardship?

MR. KEATING: Not very much. We do once in a while run across it, and if it is a real dire hardship we will give them the medicine. But in most cases they say charge it, and that is the end of it. You can't refuse an antibiotic to a baby or anything like that.

MR. TROTTER: I don't know, Mr. Chairman; perhaps Mr. Keating might offer an opinion.

Would you as a pharmacist object to some kind of insurance scheme?

MR. KEATING: Are you talking about pre-paid prescription services?

MR. TROTTER: Yes, as in Windsor, or any type of insurance scheme?

MR. KEATING: I think that would be an excellent solution to it, and I think that seems to be the trend, pre-paid in so many fields. But there is only one thing: I still think that a pre-paid scheme -- again we do not want to cut down on the pharmacy outlets -- there would be more prescriptions filled which would not make the cost any higher. I think we would need more pharmacists in the country and more dispensaries, because I think there would be a great many more prescriptions written.



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But I don't think that the cost is going to be higher. There is a little dispensing by doctors now.

MR. TROTTER: When you say there would be a lot more prescriptions written, would that mean that today people are not buying drugs who should have them?

MR. KEATING: No. I am saying that there is a lot of medication goes out through the doctors' offices, particularly in rural areas. There is a lot of medication going from the doctors' offices.

MR. BRYDEN: A lot of free samples come from the doctor's office. I know a lot give away free samples.

MR. KEATING: You should see some of the pharmaceutical shipments that go into the doctor's office, particularly in rural areas. I know one little store, and there is only 200 population, and this place is kept very busy because the doctor writes all the prescriptions. The newer drugs, I mean the new therapies here. There are a lot of tonics and things of that nature still go out from the doctors' offices.

MR. PRICE: Do you have a large credit business?

MR. KEATING: Not too much. I have always made a policy to operate without credit. I know some stores carry on considerable credit, but I have been very cautious of the credit business



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up to now.

THE CHAIRMAN: You mean with your customers or your suppliers?

MR. KEATING: No, my customers. I know some stores maybe have three hundred or four hundred or five hundred people, they buy by the month, but I don't have that type of business.

MR. PRICE: So your bad debts would not be very much?

MR. KEATING: That is right.

MR. PRICE: Would you recommend anyone to become a pharmacist?

MR. KEATING: If we get a few changes in the Pharmacy Act, I think that is a wonderful thing. But I think that now we are hampered. I think if we had hospitals under the Pharmacy Act, I think if we could have our pharmacists set up through the council with the disciplinary committee with the power to act. Now, this is not to keep pharmacy for pharmacists, but in every professional group we must have some kind of discipline. I think we could really make pharmacy an outstanding profession, and we hope in time to get this. I am not speaking pricewise and so on. The legal profession, the medical profession, and so on, they all have certain disciplinary measures, and we are limited.

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MR/dpw

Someone mentioned about cluttering up the store with merchandise. There is a so-called code of ethics of operating a dispensary. If we can get all these things into the Act I think we are going to have a wonderful attraction, wonderful feature for the pharmacist but right now with long hours and commercialism, and so on, it's just a little hard to sell.

MR. PRICE: Are there any specific changes you would like to tell the Committee about?

MR. KEATING: I have brought up those two. That is, we should have a little more strength in our licensing; where those licences to pharmacists go. I think that is where our College Council is hampered sometimes, and that, of course, would come under disciplinary action.

I think if we had stronger teeth in the Act regarding a licence that the Registrar could use you would find a great upgrading in - I am speaking particularly of retail pharmacies.

MR. BRYDEN: Could you be a little more specific in just what way the Act relating to licences should be strengthened?

MR. KEATING: You mentioned about being cluttered up with merchandise. There are some places that I don't think lends itself to professional atmosphere and yet pharmacists have gone in but I am not mentioning any particular



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I think if we had another teeth in the Act regarding a license that the Registrar could use you would find a great upstanding in - I am speaking particularly of retail pharmacies.

MR. PRICE: Could you be a little more specific in just what way the Act relating to licenses should be strengthened?

MR. KEATING: You mentioned about some places that I don't think lends itself to professional atmosphere and yet pharmacists have gone in but I am not mentioning any particular



names. I don't think that that is said in the way to keep the pharmacy to the pharmacist. I am thinking of the public image in pharmacy because I don't think you will see other professions, legal or medical, and so on, practising in some of the so-called atmospheres that some pharmacists are in. Not all. That is why we should have a little more strength in our Act.

MR. BRYDEN: Are you talking about drugstores now?

MR. KEATING: I am speaking of drugstores.

MR. WREN: Premises you were talking about?

MR. KEATING: I mean pharmacies operating within another premise, you know, that is foreign to it.

MR. BRYDEN: What is wrong with that?

MR. SUTTON: Not professional.

MR. KEATING: It depends. It can be in some cases - I mean it should be, I think we have one there which is very very close to the line and pharmacists must have complete control. I think that there should be to make sure, there should be a little more opening of bank books to see that the pharmacist has control. I don't think it would be in the interests of the public if pharmacies by any chance or somehow became controlled



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through or by monied interests because actually I am getting back to the fact that the pharmacist goes four years with pharmacy in mind because it is inherent in it - he has got a profession. He is there to serve the public, or the public health I should say. If you get a pharmacy, get too much of it right on the borderline, the pharmacy could be taken over by so-called mercenary owners, you may lose that person's professional touch.

MR. BRYDEN: But it has to a very important degree been taken over, shall we say, with mercenary owners, at least by the manufacturing ends. It is an industry of very heavy promotion, for one thing. A report that was tabled in the House of Commons recently under the Combines Act speaking about the pharmacies, I think it averages 25% spent on promotion and runs up in some cases as high as 50%. The amount of research is negligible, as far as Canadian companies are concerned and even on quality control, which is a matter upon which great stress is placed, I think certainly a very small percent of their sales, dollar costs go into that. One of the big costs in this industry is promotion really of the good old-fashioned huckster type although it admittedly is directed only to certain people so the industry is vitiated at the beginning with commercialism at the manufacturing level. It is pretty hard to carve



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the manufacturing level. It is pretty hard to carve



out a professional status in that framework, it would seem to me.

MR. KEATING: Of course I am speaking of pharmacists, actually individual pharmacists working. That is another problem for the companies to deal with. I am not speaking of them. I am speaking of the individual man, the pharmacist who graduates can migrate to this - four years course you can get a choice of hospital, retail, research, and what-not that he can specialize in and some do go into industry. I am not speaking or saying anything for that at all. I am speaking to this question of what is the attraction of the future for young people in a pharmacy.

MR. PRICE: Is there a trend today do you think in pharmacy towards a chain store operation?

MR. KEATING: Well there has been some small change opened by this. The help situation is getting the pharmacist to run them. No, I wouldn't say there has been a trend towards the chain. Some of this is co-operative where the pharmacist goes in in a part-time, or at least a part financial arrangement. It's a branch store; the pharmacist running that store maybe has control of the stock in it, and owner of that store; and the other side he has stock in the other store and 50% in the branch. I think there is a tendency to



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MR. KATLIN: Of course I am speaking

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of the stock in it, and owner of that store; and
the other side he has stock in the other store and
so in the branch. I think there is a tendency to



have a company formed where an older pharmacist forms a company, has a young pharmacist come in, makes him a partner and sells him the business when he retires but I wouldn't say there is a development in chains so much.

MR. PRICE: Do you think the hours that the pharmacist must remain open are too long?

MR. KEATING: Well sometimes I do. Some centres claim they have to be open longer. We have done very well in dealing with our shorter schedule and yet giving the service to the public.

MR. BRYDEN: You have a co-operative arrangement?

MR. KEATING: Yes, and no by-law because we have two groups, one downtown group working within itself and the outside working within itself and we work together. The public is covered. That is probably one reason why we couldn't recruit pharmacists back a while ago and this may help.

MR. BRYDEN: It may help the cost picture too. It would seem to me pretty costly to have a pharmacy open say sixteen hours a day. That means you have to have two full-time pharmacists at the store.

MR. KEATING: In some large metropolitan areas, there are pharmacies in or near medical art buildings in groups, in a location where there are groups of doctors living, and so on, and they



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MR. KEATING: In some large metropolitan

town areas, there are pharmacies in or near medical

and buildings in groups, in a location where there

are groups of doctors living, and so on, and they



are purely dispensing pharmacies and it is only in the odd places like that that the pharmacy can live on its own as a dispensing pharmacy and they can run 24 hours a day, or what-not, and that is not a cost factor. Speaking in my own case it would be suicidal for me to try and stay open 24 hours a day.

MR. BRYDEN: You wouldn't get enough business?

MR. KEATING: No, and a doctor can call any one of the pharmacists in Guelph any time at night or if a doctor wants something most of the time he just runs to the hospital and gets it from the pharmacy there. It is very seldom necessary.

MR. PRICE: Do you have any complaints about drug costs?

MR. KEATING: No. A few years ago when we first ran into antibiotics, when they were new and people didn't know about it, but a few words of explanation to the customer explained it to them.

MR. PRICE: I think you mentioned earlier you think more a matter of education?

MR. KEATING: Education, yes, and I think this here is very good, this Select Committee, as you gentlemen see all this evidence is coming out. I think this is education to the public too.

MR. BRYDEN: Some of the education I have seen submitted to the public, strikes me more in the nature of an attempt to justify high prices,



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MR. BRYDEN: Some of the education I have seen submitted to the public, strikes me more in the nature of an attempt to justify high prices,



or an attempt to give an explanation that is not necessarily true. For example, Pfizer, I think it is Pfizer put out a series of displays in some drugstores. I would like to see somebody try to justify the accuracy of everything they said in these things. Some of that education is really trying to condition them to accept something that they perhaps should not accept.

MR. KEATING: Is that display in the store?

MR. BRYDEN: Yes. I think it was Pfizer put in, you know, with emphasis on cost of research, and so on, all in the nature of ---

MR. KEATING: Oh yes, I am sorry. I remember that. I thought you were talking about a display for some products.

MR. BRYDEN: No, to justify or to explain to the public about why prices were as they were. Now they have shown a tendency recently to reduce prices, in some cases, which might be a better way to handle the problem.

MR. KEATING: That is true. There is one large pharmaceutical house that I know of and I think in the last ten years or twelve years there has not been a period longer than eight months that they haven't reduced one price, at least one price on pharmaceuticals. As I say, production steps up but sometimes - there have been price



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reductions in the last few months. I think it was brought up by Mr. Isaacson, I think the Chairman asked that question, was there any correlation to this Committee. It stands there.

MR. BRYDEN: There might be. That is one thing. Also they found their patents haven't been standing up as well as they thought. At any rate, their patents are in some degree of jeopardy. It might be a correlation of that too. Certainly tetracycline there is --

THE CHAIRMAN: This witness I don't think is qualified to deal with patents.

MR. BRYDEN: Perhaps not.

MR. WREN: Now with the Hospital Services Commission functioning for some time the place of the pharmacist is gradually shaping in that whole picture. It won't be too long before you will know exactly where you stand. Where do you think the place is going to be in a rather inevitable medical scheme?

MR. KEATING: In a which?

MR. WREN: In a provincial or national medical scheme, what will happen to the pharmacist?

MR. KEATING: I think the place of the pharmacist, and I think that we are on record as a provincial, as a Dominion Association, the pharmacist would welcome a participation in any



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national provincial health scheme providing the pharmacist operates as an individual the same as the medical man within that scheme; that the public will have the right to take the prescription to the pharmacist of their choice. I think that I am correct in what I am stating. That is more or less of what we have gone on record as.

MR.WREN: So you have no grave apprehension about your position?

MR. KEATING: No, I think that if we are taking into consideration that the pharmacist can operate as he is now - here is an observation that I picked up in some hospital reading. I can't give you the direct quotation but in out-patient dispensing in hospitals in the United States, you know they have private health hospitalization schemes, the pharmacy costs, that is cost per patient per prescription, are running higher than the retail stores because by the time they are charging the professional salaries, the light, heat, the space they occupy and all the other services rendered by the hospital to the pharmacy, and handling the medication, the prices per prescription are running higher than retail because there is no subsidization by lower cost in retail.



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We think we can do a better job at the retail level than any government scheme and can give the public a better price.

THE CHAIRMAN: And that is the real cost of drugs. The hospital must take into account those other factors.

MR. KEATING: Yes.

MR. BRYDEN: Have you any idea what proportion of dispensing is now done by hospitals as distinct from dispensing by retail druggists? Have you any idea how it breaks down?

MR. KEATING: Are you speaking of moneywise?

MR. BRYDEN: People get drugs in hospitals or they get them through druggists. Have you any idea what total proportion of dispensing is done through the retail drug stores and how much is done through the hospital?

MR. KEATING: I would not have any idea.

MR. BRYDEN: Is it an increasing percentage of it? Is an increasing percentage of it being done through hospitals, do you know?

MR. KEATING: No, I would say that the latest figures released are, as I mentioned the doctors do dispense quite a bit, but I think last year's prescription figures more or less -- and this is Ontario-wise -- are about eight to ten



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per cent increase.

MR. BRYDEN: That is through the retail pharmacies?

MR. KEATING: Through the retail pharmacies, and there was an increase because the doctors are gradually relegating the old, as it were, and taking on the new therapeutic formulas, and there is more prescribing.

After all, even though there is the Ontario Hospital Service, and the hospitals are crowded, and a doctor can call on a patient and by using the needle and some antibiotics, and following that up with a few capsules or something like that, he can in two or three days have the patient back on the way to recovery, or maybe back to work within the week. That is much better than a trip to the hospital and all that entering and so on and so forth, because hospitals are crowded and the doctor -- that maybe has some bearing on it, if he can use an antibiotic or some other medication and have that patient around again without entering the hospital. That might have some bearing, but there are more prescriptions written by physicians. It is increasing.

MR. BRYDEN: Did I hear you correctly in your presentation? Did you say there are only two Ontario hospitals that have pharmacists?

MR. KEATING: That is just what I have



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MR. BRYDEN: Did I hear you correctly

in your presentation? Did you say there are only

two Ontario hospitals that have pharmacists?

MR. KEATING: That is just what I have



heard. I think it is in London, there is a mental hospital, or one in St. Thomas. I asked for help and one of these gentlemen might know about it, but I think it is in this pharmacy department. He has included a pharmacy, but he is doing several other jobs.

MR. BRYDEN: I was a little surprised and I was not quite sure I heard right.

MR. KEATING: I am not saying this in criticism, gentlemen. The Dean told you that. We came along and back in 1930 we were handling medication as we had handled it for two thousand years. There were a few odd drugs, and then the research came along and it has developed the pharmacy and we built up our education to one, two, four years of pharmacy. Today the pharmacy is prepared to meet this new challenge, but I still think that unfortunately we are back into the picture of the 30's, yet. The people have not caught up to it. There was not hospital written into the Pharmacy Act. I think that was all. When they wrote that, it was a way back in the 30's, and all we had then was morphine, codeine, and a few things like that, and as the Dean told you, there was no therapeutic value. But things have changed so rapidly.

You have seen it through your hearing, and that is why I think that now you need pharmacists in all these institutions because they are the only

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people that are making a complete professional study of medicine.

What is pharmacy? Pharmacy is the application of the sciences of chemistry, physics and biology to the preparation and control of medicine. That is all, and we are the only group that actually are doing that. I mean, there are others in the field, but that is our business.

MR. RICE: Are there any further questions?

THE CHAIRMAN: Thank you very much, Mr. Keating, for coming and assisting us.

MR. KEATING: Thank you, Mr. Chairman.

MR. SUTTON: Have we a representative with us this afternoon from the Ontario Hospital Association?

THE CHAIRMAN: Not from the Commission, I don't think.

MR. SUTTON: I was wondering whether or not we could verify Mr. Keating's statement that the Commission have not a registered pharmacist with them. It seems strange if they spend fifteen million dollars to twenty million dollars in hospitals for drugs and they have not got a registered pharmacist.

MR. RICE: I don't think it was the Ontario Hospital Services Commission he said.

MR. TROTTER: It was the Hospital Association.



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MR. SUTTON: I am sorry, I thought it was the Commission.

THE CHAIRMAN: We can check that from the Department of Health.

MR. RICE: Mr. Chairman, the next business we have is Mr. W. Solomon from Islington.

Mr. Solomon, will you tell us your full name please?

MR. SOLOMON: William Solomon.

MR. RICE: What is your occupation?

MR. SOLOMON: I am a practising pharmacist at the Islington-Royal York and also I am associated with Kingsway Drugs Limited.

MR. RICE: Are you associated with two drug stores?

MR. SOLOMON: Six drug stores, actually, and I work at the Islington-Royal York Drug Store and also Kingsway Drugs Limited of which there are five stores.

MR. RICE: How long have you been a pharmacist?

MR. SOLOMON: In the owner capacity it is 13 years now. In pharmacy, actually since 1939 other than four years during the war.

MR. RICE: Since 1939?

MR. SOLOMON: That was when I started serving my apprenticeship.

MR. RICE: How long have you been

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Mr. Solomon, will you tell us your

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serving my apprenticeship.

MR. RICE: How long have you been



associated with the stores you have just told us about?

MR. SOLOMON: Kingsway Drugs became an entity about four or five years ago. I had my own store originally, but that was appropriated, and subsequently five years ago I moved to Islington and from that started Kingsway Drugs.

MR. RICE: In what store do you actually practise?

MR. SOLOMON: At Islington-Royal York Drug Store in Islington.

MR. RICE: Could that store be described as a typical suburban drug store or pharmacy?

MR. SOLOMON: Well, it is a little difficult to say what "typical" is. Nowadays suburban stores are broken down into two types, the plaza type of drug store which is a general merchandising type of store, and our type, which is I think a typical heavy dispensing store. It is a smaller store, but we are not general merchandising and we do more dispensing than a plaza store might.

MR. RICE: Speaking of the Royal York Pharmacy, what would be your total investment there, that is complete for all items?

MR. SOLOMON: Our complete stock or just dispensing stock?

MR. RICE: Your complete stock?

MR. SOLOMON: Islington-Royal York



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think a typical heavy dispensing store. It is a

smaller store, but we are not general merchandising

and we do more dispensing than a plaza store might.

MR. RICE: Speaking of the Royal York

Pharmacy, what would be your total investment there,

that is complete for all items?

MR. SOLOMON: Our complete stock or

just dispensing stock?

MR. SOLOMON: Just complete stock.

MR. SOLOMON: Islington-Royal York



Drugs has about \$30,000.00 worth of stock, and dispensing stock is about \$12,000.00 or \$13,000.00 worth.

MR. RICE: And of that dispensing stock, how many different items would you have in that stock?

MR. SOLOMON: I would say 2,000 2,500. We stock perhaps more than the usual drug store does.

MR. RICE: What would be your yearly turnover in drug stock?

MR. SOLOMON: In this particular store we fill about 50 prescriptions per day, that would be about 17,000 or 18,000 prescriptions a year. The average prescription price is \$3.00, \$50,000.00, I would say about four or five times.

MR. RICE: What personnel do you have attached to the store there?

MR. SOLOMON: In this particular store -- this is not the plaza type of operation, it is the heavy dispensing type store that has built up a heavy dispensing business over the years. We have two trucks, two drivers, and we have two druggists and another comes in and helps at peak hours, and we have four clerks full time and we have others that just come in part time.

MR. RICE: Of the gross sales from your store as a whole, what percentage would the



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have four clerks full time and we have others that

just come in part time.

MR. RICE: Of the gross sales from

your store as a whole, what percentage would the



prescription department contribute?

MR. SOLOMON: Our prescription department, I would say, just dispensing -- not talking about vitamins or the allied things to dispensing, but just dispensing would be about 25%, 35% of our business. With the vitamins and allied things, it might go up to as high as 50%.

THE CHAIRMAN: In other words that would emphasize the nature of the business you are doing, which is a heavier dispensing of drugs?

MR. SOLOMON: Yes.

THE CHAIRMAN: You are aware Mr. Wilkinson and some of the other witnesses the other day gave evidence to the effect that 20% might be an average?

MR. SOLOMON: Yes, but this store is a little unusual because our other stores are not anywhere near that. Some of them have even less than 20%, I would say 10%, our downtown stores.

This particular store has been an entity for about -- we have been there for five or six years and it has been there for 20 years and we think enjoys a rather favourable reputation in the area.

THE CHAIRMAN: I am familiar with that store. I think it has been there ever since I was a child when Islington was a village.

MR. SOLOMON: Yes, in Islington, and



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THE CHAIRMAN: I am familiar with that store. I think it has been there ever since I was a child when Irlington was a village.

MR. SOLOMON: Yes, in Irlington, and



when we took it over we kept up the good name, I think, and it is a little unusual in that the dispensing is heavier than in most stores.

MR. RICE: Could the store exist in that area from the sale of dispensing drugs only?

MR. SOLOMON: You mean our store?

MR. RICE: Yes.

MR. SOLOMON: If we cut out the rest of it?

MR. RICE: Yes.

MR. SOLOMON: As a matter of fact, we were seriously considering it. As a matter of fact about two or three months ago our accountants were trying to figure out whether we could as a heavy dispensing store stop selling cigarettes, cosmetics, magazines, et cetera, and continue as a dispensing business. In spite of the fact that we did that, our accountant -- mind you -- our accountant is just a little concerned because he felt we might lose out on our dispensing because we did not have the rest of the things to offer the public.

In other words, if they stopped buying their cigarettes, magazines, and hair preparations in the store, they would start cultivating new habits and we might lose our prescriptions because they would have new shopping habits. I am not sure about it, but we have thought about it quite a bit.

MR. RICE: You have not come to any



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but we have thought about it quite a bit.

MR. RICE: You have not come to any



final conclusions?

MR. SOLOMON: We have. We are not going to do it.

MR. RICE: Where do you purchase the drugs for sale, from wholesalers, or manufacturers?

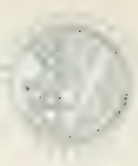
MR. SOLOMON: We purchase drugs where we get the best price for them. As it happens, we have a warehouse from which we purchase for four or five stores, and wherever we get the best price, we buy the drug. If it is Drug Trading, we buy the drug from them.

I think we can generalize by saying that most of the pharmaceuticals we purchase from the pharmaceutical companies because the discount is 40%. Other products we purchase from Drug Trading because there is usually a better market from Drug Trading.

MR. RICE: When you purchase, do you purchase collectively? Do you purchase for the five in one group and the one in the other group?

MR. SOLOMON: Only if there is an advantage we purchase collectively. In most things there is no advantage, but each store buys on its own and if there is an advantage in buying huge quantities, we do that.

MR. RICE: Would you say there are a few items you can take advantage of quantity buying for?



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MR. RICE: Would you say there are a
few items you can take advantage of quantity buying

for?



MR. SOLOMON: I should not say a few. There are quite a few items, but there are so many items in a drug store it still is a small percentage of the whole.

MR. RICE: Have you considered whether or not you should have a central warehouse or storage for the six stores?

MR. SOLOMON: We do have.

MR. RICE: And yet each one of your stores buys individually?

MR. SOLOMON: Every store has its own idiosyncracies. Our downtown stores sell far more of certain items than we do in the suburbs. They buy those things at the best possible prices. We are in the suburbs and we buy other things that they cannot sell. As I said, there are quite a few items that we do buy collectively and then pass the saving on.

MR. BRYDEN: When you refer to downtown stores, what area is that?

MR. SOLOMON: We have a store at Bay and College, in the Continental Can Building. We also have a store at Yonge and St. Mary's, and we have an interest in a store at Alexander and Yonge. Those are right downtown.

You see, we are dealing with an entirely different type of public out in the suburbs. We have people who live there with their children,



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entirely different type of public out in the suburbs. We have people who live there with their children,



and downtown we have the office workers and the transient trade, and the shoppers.

In the suburbs we sell a lot of baby items and downtown we don't. Downtown we sell tremendous quantities of cosmetics and in the suburbs, very few. Each store has to be treated as a separate entity. In fact if you go into another suburb, that suburb has its own idiosyncracies as far as drugs is concerned. You can move two or three blocks away where you have other doctors, and you will find there you will have to buy entirely differently, because those doctors prescribe certain things which the doctors three or four blocks away may not prescribe at all. So each store has to be considered almost as a separate entity.

MR. RICE: Do you have must wastage with regard to drugs?

MR. SOLOMON: I think you asked that question of Mr. Keating. In Toronto -- and I can only speak for Toronto, one thing that we have been confronted with, which is a situation that we are handling and I don't know what we are going to do about it.

It seems to have occurred in the last year or two and I attribute it to the publicity given to the high price of drugs, but many people now are bringing back unused portions of drugs and wanting refunds.



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Those are good customers of ours and it is a problem. We cannot use them, we won't use them once the drug leaves the store. We do not know what they are bringing back and we just cannot touch it. What we do, of course, is give them their money back and then we are stuck with it.

Some of the drug companies give us samples, but it is not a big percentage. It is something that is becoming a bigger problem than it was. In our overall volume it would be no more than half of one per cent, that is net profit. We have never added it onto our overhead, the cost involved in this but we do know that our net profits are shrinking and I think that is one of the reasons.

MR. RICE: If that practise continues to increase, will you have to increase the price of your drugs to compensate for it?

MR. SOLOMON: Well, yes, I suppose something like that will happen, but I have an idea that other things are going to happen before that happens, so I am not too concerned about that particular phase of it.

MR. RICE: So will you explain what these other things are that you think are likely to happen?

MR. SOLOMON: I am here speaking as an individual. I have not discussed this with any organization or group. I am just familiar with



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Toronto in my capacity as a druggist.

In our charted expansion for our group, and our dealings in our stores, we always add new members to our organization, graduate pharmacists. A problem that you are discussing right now, I felt about a year or so or two years ago, not the high price of drugs, but what was more important to me, the lack of pharmacists, and I honestly believe in Toronto anyway and I suppose all through Ontario eventually, that this is going to be the piece de resistance. I think we are on the verge of becoming a profession. I know it sounds melodramatic, perhaps, but I know for a fact very few people are interested in pharmacy. People I know whose fathers worked at it, have no intention of going into it.

I know for a fact that because I am in charge of expansion, that there are boys in Toronto right now, about 20 discount houses -- incidentally they are American companies -- and all these discount houses are putting in dispensing pharmacies. I think the ice was broken with Honest Ed.

These American interests are going to take over the pharmacies, and most of the general retailing in Toronto. That is something you can read in the Financial Post or most of the other financial magazines. I have an idea, before I am going to have to start worrying about returns



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Solomon

2511

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PB/hm

Then, of course, when they get the business to themselves, then we will really have to have an investigation to find out about the high price of drugs.

In other words pharmacy generally, right now, has a very low morale. I don't know what the fault is. There are very few students joining up. There are dozens every year dropping out. Hundreds would drop out but can't afford to drop out.

The public, perhaps not in Guelph, but certainly here -- I filled 64 prescriptions yesterday, I kept a count, and I got 13 complaints about prices. These people -- I will be more specific. A woman came to purchase a prescription. Before she gave me the prescription she showed me a bathing suit she paid \$30.00 for. I filled her prescription. I think it was \$2.80. I got a terrible complaint.

I don't think this is a new problem. I think it is something we have been aware of for a long time. I know, working in drug stores, I have always heard complaints about drugs. I think generally, the public, unless they can eat or throw out or enjoy something don't care to spend money. The pharmacist who works long hours isn't paid very much, not on his investment. He is caught in the middle. This is encouraged by our newspapers.



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The end result is ...

MR. BRYDEN: You mentioned one case where the price was only \$2.80. There are probably a lot more expensive than that. I am not saying it is your fault.

MR. SOLOMON: We have to make the public conscious of this thing. Perhaps they ought to -- I hold no brief for the manufacturer. There is the Combines Act. We should have some machinery to find out and if there is a problem we should do something about it.

I as a pharmacist was exposed to this. As a member of a very important profession I have been wondering if people do realize how important pharmacy is. We are the only people that stand between all these poisons, antibiotics, tranquillizers.

You people make the laws. We enforce them for you. If we lose the corner drug stores I don't know -- we are the ones that are subjected to this.

MR. BRYDEN: You mentioned a minute ago you held no brief for the manufacturer. I appreciate you are the man who has to deal with the public. You get all the complaints and everything else. It strikes me that the pharmacists do hold a brief for the manufacturers.

MR. SOLOMON: Which pharmacists?

MR. BRYDEN: We have had submissions



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here from people in your profession who certainly, as far as I can see do.

MR. SOLOMON: There are certain things -- we have less facts than you have, probably. I understand that these manufacturers are doing research. The people who make these generic products wait until the research is done. They don't gamble. They only take the popular. They don't make generic unpopular.

MR. BRYDEN: That is the manufacturer's line.

MR. SOLOMON: I am just quoting.

MR. BRYDEN: I am not arguing, but it seems to me it may have been done without analysing.

MR. SOLOMON: I have analysed. I hold no brief. I couldn't care less if doctors give generic. The only thing this has done, we not only get all the pharmaceuticals which were duplicated, now we have to get generic, not only generic, but certain doctors are suggesting certain types of generic -- equinol and milltown, we had metropanete -- all kinds.

As I say I hold no brief for the manufacturers. I don't know whether they are breaking laws. I didn't mean to speak on this subject, but we are the ones who are exposed to this. For this reason morale is very low. There are very few people going into pharmacy.

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MR. WREN: Where are these American -- the potential discount houses that are going into pharmacy.

MR. SOLOMON: There are all kinds just like Honest Ed.

MR. TROTTER: What American discount houses do you mean?

MR. SOLOMON: Well, both Canadian and American. It is just in the Financial Post I read there were many contemplating moving to Toronto. They always ...

MR. TROTTER: Gower, Honest Ed?

MR. SOLOMON: They have American money in them.

I have heard -- I don't have any proof except what I read in the newspapers and people I have talked to -- there is Gem. There is a big American company that is going to deal directly through the manufacturer to the public. I think it is M.G.M. or something.

MR. TROTTER: I understand pharmacy has been having a difficult time for the last few years, there has been a tendency over the last few years for young people not to want to get into pharmacy. That started long before the discount houses began or certainly the American...

MR. SOLOMON: That is quite true. It never was an appealing profession. The reason



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it didn't appeal to the general public was the hours are long and the pay is not great. Generally a father, if he is a pharmacist, his son would become a pharmacist and perhaps some frustrated doctors who couldn't afford to go into medicine wanted to get into something allied, and then perhaps some people who worked in drug stores when they were young.

MR. TROTTER: You think by allowing such as a firm as Eatons and Simpsons to have a pharmacy it is detrimental.

MR. SOLOMON: I can recall our Dean when I was going to school coming out with a very profound statement, that the biggest mistake made was allowing these limited companies. I am a limited company that is the only way I know of fighting -- allowing a company, limited company to own a drug store and hire pharmacists to work. That was going back about 30 or 40 years. That is what started. Fortunately we were able to do certain things, apply certain pressures and pharmacists were still in charge of this. He was still in charge of most of the aspects of this.

I think what really broke the ice was Honest Ed's. I am not sure, but I think it went to Court and he was allowed to continue. Subsequently two or three others started. Of course, the pharmacy Act wasn't strong enough.

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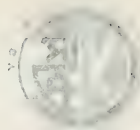


talk about Eatons or Simpsons. They are very good drug stores except they are not available for emergencies and they are not available for nights or Sundays. They don't give the service a corner drug store gives.

The discount houses can operate efficiently -- I shouldn't use the word efficiently -- more economically than the average drug store because they don't stock emergency items that we would. They don't have telephones. Their overhead is considerably less because they operate as part of a big entity. They are closed nights. They don't have to worry about people that live in their neighbourhood. They are closed Sundays. They can chop 10 or 15% off the price of their prescriptions.

Another thing, there are two or three in Toronto now and while there is only two or three they will do tremendously well because people when they want their emergency prescriptions or want something in a hurry they will phone the corner drug store to tell us or else the doctor will but the people who have repeat prescriptions over periods of years they will take these down to the discount houses and get it refilled there because they can do it at their leisure.

MR. BRYDEN: Isn't that the same



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MR. BRYDGE: Isn't that the same



with anything, if you want to fight the crowds you can get it at a discount, whether it is chairs or drugs.

MR. SOLOMON: Is it fair to the corner drug store. Suppose your baby is sick and you have to have something in a hurry, you don't go down and fight. Well, the corner drug store requires both to exist.

I mean, it is something I think in five or six years, perhaps ten, this legislative body, the one that created pharmacy is going to sit down and try to reconstruct this one of these days. This is my personal opinion. They are going to have to give the pharmacists some protection. When the corner druggist ...

MR. BRYDEN: Don't we have to make a distinction between the pharmacist as a professional man and the retail outlet to which many pharmacists have been attached. Maybe what is obsolete is the system of attaching a professional pharmacist to a retail store.

MR. SOLOMON: The pharmacist by virtue of his ethics will run an ethical store whether he has merchandise in the store or not. That is, the people in his community know regardless of what is selling in the store, nylons or anything else, as soon as you cross a certain part of the store there is ethics.

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MR. BRYDEN: Isn't that true of the discount houses?

MR. SOLOMON: Yes.

MR. BRYDEN: There is a pharmacy there?

MR. SOLOMON: Absolutely right.

MR. BRYDEN: It is ethical?

MR. SOLOMON: You are absolutely right. I don't mean that at all. I mean you get a corner drug store with merchandise strategically situated throughout the city who are theoretically cutting price of drugs -- the competition is so keen. I wonder how prices will be cut. I remember when the Fair Trade Laws were applied to hardware. Prices were going berserk. We didn't know the price of anything. Prices soared. What were the prices before?

MR. BRYDEN: I must say I never knew what they were before or after.

MR. SOLOMON: The point I am making...

MR. BRYDEN: I heard a lot of complaints.

MR. SOLOMON: Furthermore in the average drug store the pharmacist is the owner and the boss and has a certain amount of ethics. In the discount house he is in charge of this particular department. He has no say in the policy of the company at all, absolutely no say at all. Whether it is going to make for less expensive drugs in the future or not, I don't know.



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I don't know.



MR. WREN: Would you suggest we legislate him out of business?

MR. SOLOMON: No, this is free enterprise we have here. I am a firm believer in free enterprise. What I would suggest is that drugs -- I haven't prepared any brief -- I would rather have drugs less expensive and so would every pharmacist. I would rather have less duplication. If the doctors want generic, we will give it to them every time.

I wish somehow or other the pharmacist would not be stuck in the middle all the time.

MR. WREN: Would it safeguard your professional status in the community ...

MR. SOLOMON: I beg your pardon?

MR. WREN: Would it safeguard your professional status in the community if you were to accept a fee for professional services and sell drugs?

MR. SOLOMON: Unfortunately the merchant and professional men are -- yes, I would prefer to have it if we had social medicine or government controlled or something and the government would be willing to pay for all the drugs on our shelves. We could get them and charge a fee for filling the prescription. That would be the ideal situation. We have to buy the drugs and put them on our shelves and wait for them to be dispensed and then, perhaps dispense only 6 or 12



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tablets, as you can see we have to be reimbursed. A fee would not be sufficient to reimburse us.

MR. BRYDEN: It would appear what you have described as free enterprise wrong. I think if there is free enterprise it is by no means unlimited. To begin with the law says only certain have the right to dispense drugs. Probably regulation is inevitable in this particular area.

MR. SOLOMON: The only point -- I didn't mean to talk about this. I am sorry. The only point I want to suggest -- we have to compete against the drugs. It isn't profiteering. The pharmacist is caught in the middle. Unfortunately he is the one who is going to be and is exposed to the newspapers and he has the contact with the public.

I wish our Pharmacy Act was strong so that we could have some protection. This has nothing to do with the sale price of drugs, the cost of drugs -- these things are outside our profession. We are the ones that are exposed to it.

MR. WREN: For a point of information, the pharmacist who goes to work in one of these discount houses, he has the choice to accept whatever salary is offered -- he can work for \$50.00 if he wanted.

MR. SOLOMON: That is what has happened



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right now. I understand there are 500 drug stores for sale in Toronto.

MR. BRYDEN: How many?

MR. SOLOMON: I have heard there are 500 drug stores that would like to be sold. There are no takers.

The pharmacists want to earn a fairly decent salary. I think the average is \$135.00, \$125.00 -- \$135.00 a week. There are not too many drug stores in Toronto that can afford to pay that. The discount houses, Honest Ed, they can pay because they have a good thing temporarily until a bunch of others open up and the loot is divided. They are willing to pay more money for a pharmacist and a man with a family hasn't much choice.

THE CHAIRMAN: They probably pay more, have a greater volume of business.

MR. SOLOMON: They do a tremendous number of prescriptions. All these people who are using, are chronically ill and require a lot of medicine will come to my store and get a copy of the prescription and take it down to Honest Ed or some similar organization. He will chop the price 10 or 15% and give it to this person, the same person who when they are quite ill in an emergency will phone in a hurry and ask one of our trucks to deliver it to them in a hurry, no one is home, they can't leave. That is what we do.



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I don't think the public can have it both ways, something is going to give. I think our problem is one that started way back, about retailers. I am concerned about that right now. This is our problem right now. We are taking steps to attack it as best we can. One is to form a company, to open up strategically located stores. Fortunately we have got good stores, but I feel sorry for the really little guy. That is the situation we are forced into now.



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BL/dpw

MR. SUTTON: These changes that you speak of have already taken their toll of the corner grocery store.

MR. SOLOMON: That is right.

MR. SUTTON: Dominion and Loblaws have put them out of business.

MR. SOLOMON: And if I can remember correctly, sir, a few years ago there was a white paper this body brought out which showed that they could cut the price of food and still show a legitimate market.

MR. SUTTON: Would there be a trend back to the place where the butcher's shop or the grocery store that gives the service rather than push a cart through the supermarkets and pay cash, if you had the service where you call up and the man takes your meat order and delivers it?

MR. SOLOMON: In the grocery business, my own personal observation, there used to be several thousand grocery stores in Toronto, and now I think it is divided up between four or five grocery stores.

MR. SUTTON: The druggist, because of your personal status and your importance to the community, I can't see it ever happening to you.

MR. SOLOMON: Oh, yes, I can see it happening to us; I can see the signs right now. This is the trend in all retail business. This



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This is the trend in all retail business. This



began when the fair Trade laws were repealed by the Dominion Government. We have to have an organized retail business. It seemed to me that the first ones that suffered were the small manufacturing companies.

THE CHAIRMAN: We have to have stability.

MR. SOLOMON: Yes.

MR. BRYDEN: It was really well advanced, the change and what you call the fair Trade laws.

MR. SOLOMON: The trend started then.

MR. BRYDEN: It was really well advanced then?

MR. SOLOMON: Yes. Our prices were cut. We are competing with patent medicine in the grocery stores. We are given a suggested price; I think you gentlemen have all seen it. I think it is fair to the consumer and the retailer. But that was our last stronghold, the dispensary. The two stores that we had originally. That was our life-blood. But now with the slashing of prices in the dispensary because of the publicity of all these things - these people were not able to run successful drugstore operations before. I think if you checked into the background of all these people you would find that they ran drugstores but they were not very successful.



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MR. SUTTON: Have you any comment to make on the quality of the drugs they dispense?

MR. SOLOMON: I am sure they are good. They are all ethical pharmacists. I am quite sure they are doing exactly what the doctor orders and follow the directions completely. But the price of drugs - they are high - it has encouraged this, and we are destroying a profession. I know it sounds melodramatic, but I see the sign.

THE CHAIRMAN: I take it the main issue that you see is not exactly the elimination but the extinguishing of the pharmacy as a profession.

MR. SOLOMON: Yes, that is what I am afraid of, and that is the way it seems to me.

THE CHAIRMAN: And I also take it that you are concerned, when you think of the publicity that this subject matter has received in, shall we see, recent years, that it had two main effects: (1) to discourage people in adopting this as a profession, and (2), affected the public attitude toward --

MR. SOLOMON: They see me and not the manufacturer, and the people working in the stores, their morale is affected. When they are downtown they can get their prescriptions at a cut-rate store and they have us if they need us.

MR. PRICE: But only a certain



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MR. PRICE: But only a certain



percentage would fall into that category.

MR. SOLOMON: I hope you are right. I sincerely hope you are right.

MR. TROTTER: You said that of 34 prescriptions yesterday 13 complained of the price.

MR. SOLOMON: Yes.

MR. TROTTER: Would there be any particular age group of the people making the complaints?

MR. SOLOMON: No. I would say most of these 13 - there were not any children involved - I would say they are all age groups.

MR. TROTTER: Do prescriptions for older people tend to cost more?

MR. SOLOMON: You mean generally speaking?

MR. TROTTER: Yes. The older you are the more you have to have.

MR. SOLOMON: The older you are, unfortunately the more prescriptions are required, and in the long run they spend more money on prescriptions than anyone else.

MR. TROTTER: Do you come on many cases of hardship?

MR. SOLOMON: Yes, and we have done certain things about that. As a matter of fact, if you like I will tell you about them later on. We have done, our store has done what we consider - we

percentage would fall into that category.

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have a certain duty to our community, in Etobicoke, and we work hand in hand there with several organizations. I don't care to discuss it because it is not our policy to bring these things out. But in about 1% of the cases we know or the doctor has told us on the 'phone they are not able to pay much money and most times we sell it at cost, and I think most pharmacists do that.

MR. TROTTER: I would rather gather that some form of insurance scheme covering drugs would help the small druggist and hit the stores who operate on a cash and carry basis.

MR. SOLOMON: Would the prices of the prescriptions be pre-set?

MR. TROTTER: That is a general question.

MR. SOLOMON: I think it would be good generally speaking. The only thing that bothers me is if it wouldn't cost the public generally more in the long run.

MR. TROTTER: You mean an insurance scheme?

MR. SOLOMON: Yes. As far as the average pharmacist at the corner, I think it has been proved in England that the pharmacists have never had it so good, they fill more prescriptions, far more than they ever did before.

THE CHAIRMAN: Is that because people are living off the scheme?



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than they ever did before.

THE CHAIRMAN: Is that because people

are living off the system?



MR. SOLOMON: Yes. Incidentally, we all take welfare prescriptions, but the three downtown stores get most of them. People who really cannot afford the drugs in Toronto can get them because they do hundreds of prescriptions for indigents.

MR. BRYDEN: The problem isn't with the indigents, it is with the people above the indigent category, where a person gets into heavy and continuous drug costs.

MR. SOLOMON: We have to figure out what is important to us. Everything is relevant. Nobody likes to buy medicine, it is something they don't enjoy. These same people, I am sure, are driving cars, have their T.V. sets. Everything is relevant, to my way of thinking. There is nothing more important than medicine. These people who will not balk at buying something which I consider is not necessary but yet they don't like buying medicine.

MR. BRYDEN: Certainly I have known people who have lived modestly and have heavy drug bills, and I am not saying they were complaining but they were a burden.

MR. SOLOMON: Yes. I have discussed this, as a matter of fact, with two or three psychiatrists and psychologists, and they are the ones that brought this to my attention, that this constant



MR. SOMMER: Yes, incidentally, we
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complaining that we are getting in our stores about the price of drugs is getting me down. I say that I keep taking it as a personal affront, and he told me to forget about it, because people will always complain about the price of something they don't want to buy regardless of what the price is.

THE CHAIRMAN: I think I should say to you, Mr. Solomon, that in your frank discussion of this subject matter I am sure I don't think anyone should draw the impression that because you have had complaints your prices are too high, because I can assure the Committee that the prices at Mr. Solomon's stores are comparable with other drugstores. I think he is being fair and frank in telling us about these complaints.

MR. SOLOMON: Thank you. I don't want to create that impression, because I know we have always been most fair.

MR. RICE: Perhaps you might tell us how you do set your prices for prescriptions.

MR. SOLOMON: We follow the scheme that is given to us by the College of Pharmacy, which I think was in conjunction with some legislative body. We stick to that. We stick to the lowest possible.

MR. RICE: Is that practice followed in all the six stores you are associated with?

MR. SOLOMON: In every store we open

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complaining that we are selling to our stores about
the price of goods is higher than it was. I say that I
keep telling it as a general statement, and we sold me
so much about it, because people will always com-
plain about the price of something that they want to
buy regardless of what the price is.

THE CHAIRMAN: I think I should say to
you, Mr. Stoman, that in your own opinion on it
this subject is a very important one, and you
should draw the attention of the public to it. I say
complaints your prices are too high, because I can
see the Committee that the prices are too high, because I
saw the Committee with other things, and I
think he is being paid to keep the prices
down.

MR. STOMAN: Now, Mr. Chairman, I don't want
to make any statement, because I know we have
always been good to the public.
MR. CHAIRMAN: Now, you say that the
low price of goods is a very important one.

That is given to me by the College of Business,
which I think was an organization with some legis-
lative body. We stick to that. We stick to the
lowest possible.

In all the six stores you are associated with
Mr. Solomon: In every store we open



we have half of it, they each come in with us and retain 25% interest. We do not tell them what to do, but I have observed that they pretty well use the same set-up we do.

MR. RICE: These complaints that you received, would you agree with the previous witnesses that perhaps it is a lack of understanding on their part as to how the price is made up, and do you explain it to them?

MR. SOLOMON: If I can get the time and opportunity to talk to them. I find most people, particularly anyone in business, are quite happy after an explanation has been offered.

MR. RICE: Could you give us any idea as to the savings or difference in price of a prescription at your pharmacy and one at these discount houses?

MR. SOLOMON: The what, sir?

MR. RICE: Could you give us any idea as to what the difference is?

MR. SOLOMON: I am not sure what discount he offers. I can tell you why he offers it, but I couldn't tell you what it is. But I think it is 10% or 15%.

THE CHAIRMAN: I take it you are relating this to your earlier evidence about the appliance business, because you don't know what they are giving the discount from.

we have half of it, they each come in with us and
retain 25% interest. We do not tell them what to
do, but I have observed that they pretty well use
the same set-up we do.

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MR. SOLOMON: Yes. I have never had one of their prescriptions to compare it, but I presume there is some kind of a discount. I know I was approached by a drug company to put their product in and cut the price 15%. But I presume their operation is similar. There may not be any discount on their prescription prices.

MR. RICE: That may not be on all items, just a few; is that right?

MR. SOLOMON: That is true. I don't know; I couldn't say for sure.

MR. PRICE: We have heard from some of the other witnesses. A lot of people complained about the cost of drugs and they may very well be able to pay the cost. It doesn't always mean that a person who can't pay will complain. You know the customers you have pretty well. It is not always because of the hardship they complain of.

MR. SOLOMON: I would say that those people who really cannot afford it - we have told them where they can get it or how to go about it, make an application, and even those that can't afford it - this is the unfortunate part, we are the last ones to find out. But most of these cases, people, I am quite sure that it is an automatic reflex. They picked up a newspaper and found that the prices in Ontario were higher than anywhere else, and if they read that the legal fees were



Mr. [Name] [Address]

...there is a ...
...was ...
...just in ...
...there ...

Mr. [Name] [Address]

...but ...

Mr. [Name] [Address]

...about ...
...to pay ...
...person ...
...reason ...
...because ...

...people who ...
...then where ...
...make an ...
...effort is ...
...the last ...
...people, I ...
...reflex. ...
...the price ...
...etc., and ...



higher in Ontario than anywhere else in the world,
if I saw my lawyer I would ask him about it.

THE CHAIRMAN: Well, thank you very
much, Mr. Solomon, and particularly for the very
frank statements and evidence you have given.

We will adjourn till tomorrow at 2
o'clock.

MR. STONEHOUSE: Mr. Chairman, there is
one change in the report of the hearings. In
Volume 24 at page 2439 there is a remark credited to
Mr. Rice that he may not want to be credited with.
I made the remark. The words were "Even newspapers
can give the wrong impression".

--- Hearing adjourned at 4.15 p.m.

--- Reporter's note: Page 2475, line 3, atrophine
should read aminophyllin



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